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Doctor, coroner, etc. must use only standard nomenclature in Item 18. No symptoms will be listed. All diseases in Part I must be casually related. Coroner cannot certify to a death due to natural causes.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

5795
STATE FILE NUMBER

FILED FEB 27 1957

Registration District No. 277 Primary Registration District No. 4412 Registrar's No. 11

1. PLACE OF DEATH
a. COUNTY: Pike
b. CITY OR TOWN (If outside corporate limits, give TOWNSHIP only): Curryville — Inside Limits: Yes X No ☐
c. FULL NAME OF HOSPITAL OR INSTITUTION (If NOT in hospital, give location): — Length of stay in 1b:

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Missouri b. COUNTY: Pike
c. CITY OR TOWN: Curryville 0820 0 — Inside Limits: Yes ☐ No X
d. STREET ADDRESS (If outside, give location): — Reside on Farm: Yes ☐ No X

3. NAME OF DECEASED (Type or print): First: Ida Middle: Belle Last: Derrick

4. DATE OF DEATH Month: Feb Day: 12, Year: 1957

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED ☐ **NEVER MARRIED** ☐ **WIDOWED** X 2 **DIVORCED** ☐

8. DATE OF BIRTH: 1862

9. AGE (In years last birthday): 95 — IF UNDER 1 YEAR: Months, Days — IF UNDER 24 HRS.: Hours, Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10b. KIND OF BUSINESS OR INDUSTRY: Home

11. BIRTHPLACE (City and state or country): Ohio

12. CITIZEN OF WHAT COUNTRY? US

13. FATHER'S NAME: William Spencer

14. MOTHER'S MAIDEN NAME: Mary Ann Drake

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, No, or unknown): No — (If yes, give war or dates of service):

16. SOCIAL SECURITY NO.:

17. INFORMANT Address: Ralph Derrick, Curryville, Mo

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Minor cerebral hemorrhage — INTERVAL BETWEEN ONSET AND DEATH: 2 days
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.
DUE TO (b): Arteriosclerosis — 10 yrs plus
DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Dementia, Old Age. 331X

19. WAS AUTOPSY PERFORMED? YES ☐ NO X

20a. ACCIDENT ☐ **SUICIDE** ☐ **HOMICIDE** ☐

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 2 — ---

20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year — ---

20d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

20e. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)

20f. CITY, TOWN, OR LOCATION COUNTY STATE

21. I attended the deceased from 1948, to 2/12/57 and last saw her alive on 2/11/57
Death occurred at 2:00 P m on the date stated above; and to the best of my knowledge, from the causes stated.

22a. SIGNATURE Charles P. Lewellen (Degree or title) M.D.

22b. ADDRESS Louisiana, Missouri

22c. DATE SIGNED 2/14/57

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE: Feb 14, 1957

23c. NAME OF CEMETERY OR CREMATORY: Laddonia Cemetery

23d. LOCATION (City, town, or county) (State): Laddonia, Missouri

24. FUNERAL DIRECTOR: William B Waters — ADDRESS: Vandalia, Mo.

25. DATE RECD. BY LOCAL REG.: 2/19/57

26. REGISTRAR'S SIGNATURE: Bill Robinson

(Licensed Embalmer's Statement on Reverse Side)

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was en

by me, or by ....., Student Embalmer No.....

working under my personal supervision..

Student.....
Signature of Student Embalmer

Signed William B. Waters

Licensed Embalmer No. 41

P. O. Address Vandalia

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (
to comply with the above constitutes grounds for revocation of license).

If embalmed by a STUDENT, he also shall sign in his OWN handwriting.

If this body is not embalmed, fact should be so stated above.