

FILED MAR 25 1957

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATHState File No. **7449**

| | | | | | | | |
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| BIRTH NO. _____ | | REG. DIST. NO. <u>1</u> | | PRIMARY REG. DIST. NO. <u>3000</u> | | Registrar's No. <u>102</u> | |
| 1. PLACE OF DEATH a. COUNTY Adair | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Missouri b. COUNTY Sullivan | | | |
| b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Kirksville | | c. LENGTH OF STAY (in this place) <u>1 day</u> | | c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Green City | | <u>1050</u> | |
| d. FULL NAME OF HOSPITAL OR INSTITUTION Kirksville Osteopathic Hospital | | | | d. STREET ADDRESS (If rural, give location) No street address | | | |
| 3. NAME OF DECEASED (Type or Print) a. (First) Maggie | | b. (Middle) Imogene | | c. (Last) McEntire | | 4. DATE OF DEATH (Month) (Day) (Year) Mar. 11, 1957 | |
| 5. SEX Female | | 6. COLOR OR RACE White | | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married | | 8. DATE OF BIRTH Sept. 20, 1900 | |
| 9. AGE (to years last birthday) 56 | | 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) Telephone operator | | | | 10b. KIND OF BUSINESS OR INDUSTRY Communications | | 11. BIRTHPLACE (State or foreign country) Missouri | |
| 12. CITIZEN OF WHAT COUNTRY? USA | | | | 13a. FATHER'S NAME Robert Byron Head | | 13b. MOTHER'S MAIDEN NAME Georgie Ann Franklin | |
| 14. NAME OF HUSBAND OR WIFE Lawrence McEntire | | | | 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No | | | |
| 16. SOCIAL SECURITY NO. 498-34-8096 | | | | 17. INFORMANT'S SIGNATURE OR NAME ADDRESS Lawrence McEntire, Green City, Mo. | | | |
| 18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) | | MEDICAL CERTIFICATION | | | | INTERVAL BETWEEN ONSET AND DEATH | |
| I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <i>Hypertensive arteriosclerotic heart</i> | | ANTECEDENT CAUSES | | | | DUE TO (b) _____ | |
| *This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death. | | Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. | | | | DUE TO (c) _____ | |
| II. OTHER SIGNIFICANT CONDITIONS | | Conditions contributing to the death but not related to the disease or condition causing death. | | | | | |
| 19a. DATE OF OPERATION | | 19b. MAJOR FINDINGS OF OPERATION | | | | 20. AUTOPSY? <u>2</u> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 21a. ACCIDENT SUICIDE HOMICIDE (Specify) | | 21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE) | | <u>4200</u> | |
| 21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.) | | 21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21f. HOW DID INJURY OCCUR? | | | |
| 22. I hereby certify that I attended the deceased from <u>2-10</u> , 19 <u>57</u> , to <u>3-11</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>3-11</u> , 19 <u>57</u> , and that death occurred at <u>3:31 A.M.</u> , from the causes and on the date stated above. | | | | | | | |
| 23a. SIGNATURE (Degree or title) <i>Wm B Reed</i> | | | | 23b. ADDRESS <i>Green City, Mo</i> | | 23c. DATE SIGNED <i>3-13-57</i> | |
| 24a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 24b. DATE March 13, 1957 | | 24c. NAME OF CEMETERY OR CREMATORY Mt. Olivet Cemetery | | 24d. LOCATION (City, town, or county) (State) Green City, Mo. | |
| DATE REC'D BY LOCAL REG. 3-16-1957 | | REGISTRAR'S SIGNATURE <i>Darius W. Ratliff</i> | | 25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <i>Glen E. Grant & Son, Green City, Mo.</i> | | | |

(Licensed Embalmer's Statement on Reverse Side)

WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

535
6

FEB 18 1958

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or by _____

Student Embalmer No. _____

working under my personal supervision.

Student _____
Student Embalmer

Signed Karl R. Kent

Licensed Embalmer No. 4689

P. O. Address Green City, Mo.

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

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