

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

7521

FILED APR 9 - 1957

Registration District No. 11 Primary Registration District No. 4024 Registrar's No. 19

STATE FILE NUMBER

1. PLACE OF DEATH a. COUNTY <u>Barry</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Barry</u>			
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Cassville</u>			Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <u>Exeter</u>		Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>Community Hosp.</u>			Length of stay in lb <u>3 wks.</u>	d. STREET ADDRESS (If outside, give location) <u>4 Mi. S. W.</u>			Reside on Farm Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <u>MAGGIE</u> Middle <u>LACEY</u> Last <u>LACEY</u>				4. DATE OF DEATH Month <u>Mar.</u> Day <u>27</u> Year <u>1957</u>			
5. SEX <u>female</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH <u>Jan. 31, 1881</u>	9. AGE (In years last birthday) <u>76</u>	IF UNDER 1 YEAR Months <u>7</u> Days <u>6</u> Hours <u>0</u> Min. <u>0</u>	IF UNDER 24 HRS. Hours <u>0</u> Min. <u>0</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>home</u>		11. BIRTHPLACE (City and state or country) <u>Illinois</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>William H. Cole</u>				14. MOTHER'S MAIDEN NAME <u>Racheal Maxwell</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>no</u>		17. INFORMANT <u>O.W. Lacey</u> Address <u>Exeter, Missouri</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Embolism</u>						INTERVAL BETWEEN ONSET AND DEATH <u>10 hrs.</u>	
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.						DUE TO (b) <u>Surgical Neck Fracture of Right Femur</u>	
						DUE TO (c) _____	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						19. WAS AUTOPSY PERFORMED? <u>0</u> YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Hour _____ a. m. _____ p. m.							
20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		20e. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)		20f. CITY, TOWN, OR LOCATION <u>005</u> COUNTY _____ STATE _____			
21. I attended the deceased from <u>March 6, 1957</u> to <u>March 27, 1957</u> and last saw her <u>alive</u> on <u>March 27, 1957</u> Death occurred at <u>6:00 A.</u> m on the date stated above; and to the best of my knowledge, from the causes stated.							
22a. SIGNATURE (Degree or title) <u>James E. Bradley, D.O.</u>				22b. ADDRESS <u>Cassville, Mo</u>		22c. DATE SIGNED <u>3/29/57</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE <u>3-29-1957</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Maplewood Cemetery</u>		23d. LOCATION (City, town, or county) (State) <u>Exeter, Missouri</u>		
24. FUNERAL DIRECTOR <u>Culver's</u>		ADDRESS <u>Cassville, Mo.</u>		25. DATE RECD. BY LOCAL REG. <u>4-3-1957</u>		26. REGISTRAR'S SIGNATURE <u>Grace Williams</u>	

Health, Welfare, Public Service  
000-56  
Doctor, coroner, etc. must use only standard form. Coroner cannot certify to a death due to natural causes. Diseases in Part I must be causally related. Coroner cannot certify to a death due to natural causes.  
0-0

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

BARRY COUNTY HEALTH UNIT  
CASSVILLE, MO.

NO. 457-55

DATE REC. 4-8-57

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was em-  
by me, or by ....., Student Embalmer No.....  
working under my personal supervision...

Student .....  
Signature of Student Embalmer

Signed Paul D. Henbest

Licensed Embalmer No. 415

P. O. Address Cassville

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.