

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

8320

FILED APR 1 - 1957

STATE FILE NUMBER

Registration District No. 128 Primary Registration District No. 2000 Registrar's No. 283

1. PLACE OF DEATH a. COUNTY <u>Greene</u>			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Webster</u>		
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Springfield</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <u>Marshfield</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>1526 St. Louis</u>		Length of stay in lb <u>55 yrs.</u>	d. STREET ADDRESS <u>E. Washington St.</u>		(If outside, give location) Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) <u>Idonia Catherine Moore</u>			4. DATE OF DEATH <u>Mar. 24, 1957</u>		
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>3-7-1870</u>	9. AGE (In years last birthday) <u>87</u>	IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </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>Bellaire, Ohio</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>
13. FATHER'S NAME <u>James T. Marshall</u>			14. MOTHER'S MAIDEN NAME <u>Mary Ann Bickel</u>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>	17. INFORMANT <u>Mrs. Earl Thomas-Springfield, Mo.</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>Hemorrhage, cerebral</u>					INTERVAL BETWEEN ONSET AND DEATH <u>4 days</u>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.					DUE TO (b) _____ 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? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT <input checked="" 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.) <u>Hemorrhage, cerebral - I think are considered an accident.</u>				
20c. TIME OF INJURY Hour _____ a. m. _____ p. m. _____					
20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>	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 <u>3, 19, 57</u> to <u>3, 24, 57</u> and last saw her alive on <u>3, 23, 57</u> Death occurred at <u>3:00a.</u> m on the date stated above; and to the best of my knowledge, from the causes stated.					
22. SIGNATURE <u>[Signature]</u> (Degree or title) <u>0</u>			22b. ADDRESS <u>505 Medical Arts Bldg. Springfield, Missouri</u>		
22c. DATE SIGNED <u>3, 25, 57</u>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE <u>3-26-1957</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Marshfield Cemetery</u>	23d. LOCATION (City, town, or county) (State) <u>Marshfield, Missouri</u>		
24. FUNERAL DIRECTOR <u>[Signature]</u> ADDRESS <u>Springfield, Mo.</u>		25. DATE RECD. BY LOCAL REG. <u>3-25-57</u>	26. REGISTRAR'S SIGNATURE <u>[Signature]</u>		

(Licensed Embalmer's Statement on Reverse Side)

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

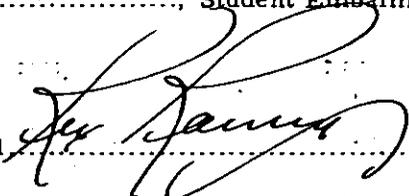
Doctor, coroner, etc. must use only standard nomenclature in reporting diseases in Part I must be casually related. Coroner cannot certify to a death due to natural causes.

APR 17 1957

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 _____
Signature of Student Embalmer

Signed  _____
Licensed Embalmer No. 3312

P. O. Address Springfield

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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.
If this body is not embalmed, fact should be so stated above.