

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

9525

FILED APR 11 1957

STATE FILE NUMBER

Registration District No. 272 Primary Registration District No. 4402 Registrar's No. 16

Health & Welfare  
Public  
Service

S. 300  
1-56

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

1. PLACE OF DEATH a. COUNTY <u>Demiseat</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Demiseat</u>					
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Denton</u> <u>0780</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		c. CITY OR TOWN <u>Denton</u> <u>0780</u>		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>			
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION			Length of stay in lb <u>Life</u>		d. STREET ADDRESS <u>Steele mo Rt</u>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First <u>Jennie</u> Middle <u>Green</u> Last <u>Green</u>				4. DATE OF DEATH Month <u>3</u> Day <u>11</u> Year <u>57</u>					
5. SEX <u>F</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>12-7-1867</u>		9. AGE (In years last birthday) <u>89</u>		IF UNDER 1 YEAR IF UNDER 24 HRS. Month <u>3</u> Day <u>4</u> Hours <u></u> Min. <u></u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, open if retired) <u>Home work</u>			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (City and state or country) <u>Denton Mo</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		
13. FATHER'S NAME <u>Josiah Denton</u>				14. MOTHER'S MAIDEN NAME <u>Mary Jane Lester</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.		17. INFORMANT <u>Went Green</u> Address <u>Steele Rt 3</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>Respiratory failure</u> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. } DUE TO (b) <u>Cardiac De-compensation</u> DUE TO (c) <u>Hypertension</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH, BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (n) <u>Senility</u>								INTERVAL BETWEEN ONSET AND DEATH <u>Immediate</u> <u>2 days</u> <u>several years</u>	
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.)					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20c. TIME OF INJURY Hour <u></u> Month <u></u> Day <u></u> Year <u></u> a. m. <u></u> p. m. <u></u>									
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		COUNTY		STATE	
21. I attended the deceased from <u>3/9/57</u> to <u>3/11/57</u> and last saw her <u>alive</u> on <u>3/11/57</u> Death occurred at <u>4</u> m on the date stated above; and to the best of my knowledge, from the causes stated.									
22a. SIGNATURE (Degree or title) <u>Robert Barlett D.O. 2</u>				22b. ADDRESS <u>Steele, Mo.</u>			22c. DATE SIGNED <u>14 Mar. 57</u>		
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE <u>3-13-57</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Green Cem.</u>		23d. LOCATION (City, town, or county) (State) <u>Denton MO</u>				
24. FUNERAL DIRECTOR <u>Hermon Tull Co.</u> ADDRESS <u>Steele Mo</u>				25. DATE RECD. BY LOCAL REG. <u>4-1-57</u>		26. REGISTRAR'S SIGNATURE <u>R. O. W. ...</u>			

4-84-57

APR 9 1957

PERMISCOT COUNTY HEALTH DEPARTMENT  
COURTHOUSE , PHONE 79  
CARUTHERSVILLE, MO.

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 *John H. German*

Licensed Embalmer No. *4359*

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