. Health,
& Welfare
. Public
h Service

S. 300
v. 1-56

FILED APR 10 1957

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

9784
STATE FILE NUMBER

Registration District No. 314 Primary Registration District No. 6059 Registrar's No. 11

1. PLACE OF DEATH
a. COUNTY St. Clair
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN VISTA — Inside Limits Yes ☑ 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 St. Clair
c. CITY OR TOWN VISTA 0930 0 — Inside Limits Yes ☑ No ☐
d. STREET ADDRESS (If outside, give location) — Reside on Farm Yes ☐ No ☐

3. NAME OF DECEASED (Type or print) First SARAH Middle LEE Last LOFTEN
4. DATE OF DEATH Month MARCH Day 20, Year 1957
5. SEX FEMALE
6. COLOR OR RACE WHITE
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☑ DIVORCED ☐
8. DATE OF BIRTH DEC. 3-1862
9. AGE (In years last birthday) 94 — 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) HOUSEKEEPING
10b. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (City and state or country) North CAROLINA
12. CITIZEN OF WHAT COUNTRY? U.S.A
13. FATHER'S NAME John WARD
14. MOTHER'S MAIDEN NAME Sally Wolford
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. NONE
17. INFORMANT WARD LOFTEN Address VISTA 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) Hypostatic pneumonia — INTERVAL BETWEEN ONSET AND DEATH 3 day
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) senility
DUE TO (c)
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Hypertension - arteriosclerotic 447X
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☑
20a. ACCIDENT ☐ SUICIDE ☑ HOMICIDE ☐
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. 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 1940, to 3-20-57 and last saw her/him alive on 3-19-57
Death occurred at 12:30 NOON m on the date stated above; and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) Ruth Seevers MD
22b. ADDRESS Osceola Mo
22c. DATE SIGNED 3-21-57

23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL
23b. DATE MAR 22-57
23c. NAME OF CEMETERY OR CREMATORY UNION
23d. LOCATION (City, town, or county) VISTA (State) MO

24. FUNERAL DIRECTOR Goodrich F. HOME - ADDRESS OSCEOLA MO
25. DATE RECD. BY LOCAL REG. 3-21-57
26. REGISTRAR'S SIGNATURE Ruth Seevers

(Licensed Embalmer's Statement on Reverse Side)

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

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STATEMENT BY LICENSED EMBALMER

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

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

working under my personal supervision..

Student.....
Signature of Student Embalmer

Signed F B Goodrich

Licensed Embalmer No. 303

P. O. Address Osceola

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Fa
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.