

FILED MAR 25 1957

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

STATE FILE NUMBER

Registration District No. 337 Primary Registration District No. 4497 Registrar's No. 25

1. PLACE OF DEATH				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)			
a. COUNTY <u>SHELBY</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		a. STATE <u>MO</u>		b. COUNTY <u>SHELBY</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>CLARENCE</u>		Length of stay in 1b <u>20 YRS</u>		c. CITY OR TOWN <u>CLARENCE</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>HOME</u>		Length of stay in 1b <u>20 YRS</u>		d. STREET ADDRESS (If outside, give location) <u>CLARENCE MO</u>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)				4. DATE OF DEATH			
First <u>NELLIE</u> Middle <u>H</u> Last <u>SANDERS</u>				Month <u>MARCH</u> Day <u>15</u> Year <u>1957</u>			
5. SEX <u>FEMALE</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>DEC 26 1874</u>	
9. AGE (In years last birthday) <u>78</u>		IF UNDER 1 YEAR Months <u>0</u> Days <u>0</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>HOUSEWIFE</u>		11. BIRTHPLACE (City and state or country) <u>MO SHELBY COUNTY</u>		12. CITIZEN OF WHAT COUNTRY? <u>US</u>	
13. FATHER'S NAME <u>GEORGE L. HOPPER</u>				14. MOTHER'S MAIDEN NAME <u>DELLA PURCELL</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) <u>NO</u>		16. SOCIAL SECURITY NO. <u>NONE</u>		17. INFORMANT <u>ENGIE NE SANDERS HANNIBAL 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>Mitral Regurgitation</u>							INTERVAL BETWEEN ONSET AND DEATH <u>7 hour</u>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.							
DUE TO (b) <u>Secondary Anemia</u>							<u>2 years</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? YES <input type="checkbox"/> NO <input checked="" 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 <u>          </u> Month, Day, Year 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>Mar. 3, 1957</u> , to <u>Mar. 15, 1957</u> and last saw her <sup>her</sup> <sub>alive</sub> on <u>Mar. 13, 1957</u> Death occurred at <u>12:15</u> A. m. on the date stated above; and to the best of my knowledge, from the causes stated.							
22a. SIGNATURE (Degree or title) <u>Dr. B. H. Edrington D.O.</u>				22b. ADDRESS <u>Clarence, Mo.</u>		22c. DATE SIGNED <u>3-15-57</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE <u>3-17-56</u>		23c. NAME OF CEMETERY OR CREMATORY <u>MAPLE WOOD CEMETERY</u>		23d. LOCATION (City, town, or county) (State) <u>CLARENCE MO</u>	
24. FUNERAL DIRECTOR <u>Chas V. Greeny</u>		ADDRESS <u>Clarence Mo</u>		25. DATE RECD. BY LOCAL REG. <u>mar-18-57</u>		26. REGISTRAR'S SIGNATURE <u>Ada Garrison</u>	

MEDICAL CERTIFICATION

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed. All diseases in Part I must be causally related. Coroner cannot certify to a death due to natural causes.

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All symptoms will be listed. All diseases in Part I must be causally related. Coroner cannot certify to a death due to natural causes.

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(Licensed Embalmer's Statement on Reverse Side)

APR 11 1957

SEP 11 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 *Charles V. Green*

Licensed Embalmer No. 46

P. O. Address *Clarence*

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.