

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

11852

STATE FILE NUMBER

67

FILED APR 9 - 1957

360

Primary Registration District No. 3076

Registrar's No.

Health,
Welfare
Public
Service

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>Vernon</u>		2. USUAL RESIDENCE (Where deceased lived. If institutional: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Vernon</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Nevada</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		c. CITY OR TOWN <u>Nevada</u> ¹⁰⁸² 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>Nevada Hospital</u> Length of stay in 1b		d. STREET ADDRESS (If outside, give location) <u>East Allison</u> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Erna</u> Middle <u>Porter</u> Last <u>Gooding</u>			4. DATE OF DEATH Month <u>March</u> Day <u>16</u> Year <u>1957</u>
5. SEX <u>Female</u>	6. COLOR OR RACE <u>Wh</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>October 9 1878</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>Own home</u>	11. BIRTHPLACE (City and state or country) <u>Adair, Missouri</u>
13. FATHER'S NAME <u>H. M. Parker</u>		14. MOTHER'S MAIDEN NAME <u>Lucinda</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>Clifford Porter</u> Address <u>1411 N. Main Nevada, Mo.</u>			12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</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>Pulmonary Embolism</u> DUE TO (b) <u>Fracture R Hip</u> DUE TO (c) _____ Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. <u>9040</u>			INTERVAL BETWEEN ONSET AND DEATH <u>50 MIN</u> <u>6 days.</u>
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"/> <u>2</u>
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>FELL AT HOME. FRACTURED R HIP</u>	
20c. TIME OF INJURY Hour <u>9:00</u> a. m. <u>AM</u> Month <u>3</u> Day <u>16</u> Year <u>1957</u>			
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.) <u>Home</u>	
		20f. CITY, TOWN, OR LOCATION <u>NEVADA</u> COUNTY <u>VERNON</u> STATE <u>MO</u>	
21. I attended the deceased from <u>March 10 1957</u> <u>3:30 AM</u> on the date stated above; and to the best of my knowledge, from the causes stated. Death occurred at <u>Mar 16 1957</u> <u>3:30 AM</u> her last saw him alive on <u>3-16-57</u>			
22a. SIGNATURE <u>Wm. J. Miller M.D.</u> (Degree or title)		22b. ADDRESS <u>Nevada Mo</u>	
22c. DATE SIGNED <u>3-25-57</u>			
23a. BURIAL, CREMATION, OR REMOVAL (Specify) <u>Burial</u>		23b. DATE <u>1957</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Newton Burial Park</u>		23d. LOCATION (City, town, or county) (State) <u>Nevada Missouri</u>	
24. FUNERAL DIRECTOR <u>Key Funeral Home</u> ADDRESS <u>Nevada</u>		25. DATE RECD. BY LOCAL REG. <u>4-3-1957</u>	
		26. REGISTRAR'S SIGNATURE <u>Anna G. Ferry</u>	

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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 embalmed by me, or by, Student Embalmer No. working under my personal supervision..

Student.....
Signature of Student Embalmer

Signed *S. Augustus Ferry*.....
Licensed Embalmer No. 490

P. O. Address *Florida*

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.