

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

12131

State File No. \_\_\_\_\_

FILED APR 29 1957

BIRTH NO. \_\_\_\_\_ REG. DIST. NO. 37 PRIMARY REG. DIST. NO. 4049 Registrar's No. 21

WRITE PLAINLY—USING UNFAADING BLACK INK—MAKE A PERMANENT RECORD

|  |                               |  |  |  |   |
|--|-------------------------------|--|--|--|---|
| 1. PLACE OF DEATH<br>a. COUNTY <b>Boone</b>  |                               |  | 2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)<br>a. STATE <b>Missouri</b> b. COUNTY <b>Boone</b>   |  |   |
| b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <b>Centralia</b>  |                               | c. LENGTH OF STAY (in this place) <b>5 years</b>   | c. CITY OR TOWN <b>Centralia</b>   |  | d. Is Residence within limits of a city or incorporated town? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> |
| d. FULL NAME OF HOSPITAL OR INSTITUTION <b>Hulen Nursing Home, Centralia, Mo.</b>  |                               |  | e. STREET ADDRESS (If rural, give location) <b>Hulen Nursing Home 0100 0</b>   |  |   |
| 3. NAME OF DECEASED (Type or Print)<br>a. (First) <b>Johanna</b> b. (Middle) <b>-</b> c. (Last) <b>Glass</b>   |                               |  | 4. DATE OF DEATH (Month) (Day) (Year) <b>April, 24, 1957</b>   |  |   |
| 5. SEX <b>female</b>   | 6. COLOR OR RACE <b>white</b> | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <b>Widowed</b>                                  | 8. DATE OF BIRTH <b>unknown</b>  | 9. AGE (In years last birthday) <b>about 95</b>  | IF UNDER 1 YEAR Days _____ Hours _____ Min. _____   |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>housewife</b>   |                               | 10b. KIND OF BUSINESS OR INDUSTRY <b>housewife</b>   | 11. BIRTHPLACE (City and State or Foreign Country) <b>St. Louis, Missouri</b>  |  | 12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>  |
| 13a. FATHER'S NAME <b>Patrick Lyons</b>  |                               | 13b. MOTHER'S MAIDEN NAME <b>Mary Dugan</b>  |  | 14. NAME OF HUSBAND OR WIFE _____  |   |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>no</b> (If yes, give war or dates of service)   |                               | 16. SOCIAL SECURITY NO. <b>none</b>  | 17. INFORMANT'S SIGNATURE OR NAME ADDRESS <b>Mrs. Tom Jones, Thompson, Mo.</b>   |  |   |
| 18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)<br><br>*This does not mean the mode of dying, such as heart failure, asthma, etc. It means the disease, injury, or complication which caused death.                                     |                               |  | MEDICAL CERTIFICATION<br><b>Cerebral arteriosclerosis with encephalomalacia.</b>   |  | INTERVAL BETWEEN ONSET AND DEATH <b>years</b>   |
| I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) _____<br><br>ANTECEDENT CAUSES<br><i>Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.</i><br><br>DUE TO (b) _____<br><br>DUE TO (c) _____               |                               |  | II. OTHER SIGNIFICANT CONDITIONS<br><i>Conditions contributing to the death but not related to the disease or condition causing death.</i> |  |   |
| 19a. DATE OF OPERATION _____   |                               | 19b. MAJOR FINDINGS OF OPERATION _____   |  | 20. AUTOPSY? <b>2</b><br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |   |
| 21a. ACCIDENT SUICIDE HOMICIDE (Specify) _____   |                               | 21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) _____         | 21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE) <b>332x</b>  |  |   |
| 21d. TIME OF INJURY (Month) (Day) (Year) (Hour) _____  |                               | 21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | 21f. HOW DID INJURY OCCUR? _____   |  |   |
| 22. I hereby certify that I attended the deceased from <b>12/27/56</b> , 19____, to <b>4/22/57</b> , 19____, that I last saw the deceased alive on <b>4/22/57</b> , 19____, and that death occurred at _____ m., from the causes and on the date stated above. |                               |  |  |  |   |
| 23a. SIGNATURE (Degree or title) <b>Robert Ward M.D.</b>   |                               |  | 23b. ADDRESS <b>Centralia, Missouri</b>  |  | 23c. DATE SIGNED <b>4/27/57</b>   |
| 24a. BURIAL, CREMATION, REMOVAL (Specify) <b>burial</b>  |                               | 24b. DATE <b>4-29-57</b>   | 24c. NAME OF CEMETERY OR CREMATORY <b>St. Brendan's cemetery</b>   | 24d. LOCATION (City, town, or county) (State) <b>Mexico, Missouri</b>                        |   |
| DATE REC'D BY LOCAL REG. <b>Apr. 27-1957</b>   |                               | REGISTRAR'S SIGNATURE <b>Maud Mc Bride</b>   |  | 25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <b>Crest-Houston Mexico, Mo.</b>                    |   |

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1958  
JAN 8 1957  
JAN 29 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 Ralph T. Hueston  
Licensed Embalmer No. 4687

P. O. Address Mexico, Missouri

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.