

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.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

12459

STATE FILE NUMBER

FILED APR 16 1957

Registration District No. 61 Primary Registration District No. 4107 Registrar's No. 13

| | | | | | | | |
|---|----------------------------------|---|--|--|---|---|---|
| 1. PLACE OF DEATH a. COUNTY <u>Cedar</u> | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>mo</u> b. COUNTY <u>Cedar</u> | | | |
| b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>El Dorado Spgs</u> | | Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> | | c. CITY OR TOWN <u>El Dorado Spgs</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>210 N. Kirkpatrick</u> | | | Length of stay in lb <u>25 yrs.</u> | d. STREET ADDRESS (If outside, give location) <u>210 N. Kirkpatrick</u> | | | Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> |
| 3. NAME OF DECEASED (Type or print) <u>SARAH JANE RILEY</u> | | | | 4. DATE OF DEATH Month <u>4</u> - Day <u>12</u> - Year <u>57</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>Feb. 4, 1861</u> | | 9. AGE (In years last birthday) <u>96</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 | | 11. BIRTHPLACE (City and state or country) <u>Cedar co mo</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>U S A</u> | |
| 13. FATHER'S NAME <u>ROBERT WILLIAMS</u> | | | | 14. MOTHER'S MAIDEN NAME <u>ELIZA CASEY</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>NO</u> | | 17. INFORMANT <u>FROM RECORDS</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>Anoxia</u> | | | | | | INTERVAL BETWEEN ONSET AND DEATH | |
| Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. | | DUE TO (b) <u>Pulmonary edema</u> | | DUE TO (c) <u>Chronic myocarditis</u> | | 1 week | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>4222</u> | | | | | | 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 _____ a. m. _____ p. m. Month, Day, Year _____ | | | | | | | |
| 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>3-16-57</u> to <u>4-12-57</u> and last saw ^{her} _{him} alive on <u>4-12-57</u> Death occurred at <u>10:30 a</u> m on the date stated above; and to the best of my knowledge, from the causes stated. | | | | | | | |
| 22a. SIGNATURE <u>Ch Sunderwith DO</u> | | | | 22b. ADDRESS <u>El Dorado Spgs.</u> | | 22c. DATE SIGNED <u>4-13-57</u> | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | | 23b. DATE <u>4-15-57</u> | 23c. NAME OF CEMETERY OR CREMATORY <u>City of Martin</u> | | 23d. LOCATION (City, town, or county) (State) <u>El Dorado Spgs mo</u> | | |
| 24. FUNERAL DIRECTOR <u>Mapes El Dorado Spgs mo</u> | | | | ADDRESS <u>mo</u> | | 25. DATE RECD. BY LOCAL REG. <u>4-14-57</u> | 26. REGISTRAR'S SIGNATURE <u>George W. Mapes</u> |

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 *George W. Mafes*.....

Licensed Embalmer No. *2752*

P. O. Address *El Dorado Ark*

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.