

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

14114

STATE FILE NUMBER

FILED MAY 1 - 1957

Registration District No. 255 Primary Registration District No. 4387 Registrar's No. 10

Health,  
Welfare  
Public  
Service

300  
1-56

All diseases will be listed. All 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

1. PLACE OF DEATH a. COUNTY <b>Oregon</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Missouri</b> b. COUNTY <b>Oregon</b>					
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>Alton</b>		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>		c. CITY OR TOWN <b>Alton</b>		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>			
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION			Length of stay in lb <b>lifetime</b>		d. STREET ADDRESS (If outside, give location)		Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First <b>Florence</b> Middle <b>Carolyn</b> Last <b>Millsep</b>				4. DATE OF DEATH Month <b>April</b> Day <b>23</b> Year <b>1957</b>					
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>Mar. 19, 1865</b>		9. AGE (In years last birthday) <b>92</b>	IF UNDER 1 YEAR Months <b>1</b> Days <b>4</b> Hours <b></b> Min. <b></b>		
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>Domestic</b>		11. BIRTHPLACE (City and state or country) <b>Alton, Missouri</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>		
13. FATHER'S NAME <b>John A. Whitten</b>				14. MOTHER'S MAIDEN NAME <b>Lucretia Nicholson</b>					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>			16. SOCIAL SECURITY NO. <b>None</b>		17. INFORMANT <b>Nora Parrott, Alton, Missouri</b>			Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Pneumonia - acute</b> <b>Dyspnea - Asthmatic</b> Conditions, if any, which gave rise to above cause (b), stating the underlying cause last. DUE TO (b) <b>Pneumonia</b> DUE TO (c) <b>Stroke</b>							INTERVAL BETWEEN ONSET AND DEATH <b>None</b>		
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.)					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20c. TIME OF INJURY Hour <b></b> Month <b></b> Day <b></b> Year <b></b> a. m. <b></b> p. m. <b></b>									
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 <b>Nov 15 1957</b> to <b>April 23 1957</b> and last saw her <b>alive on</b> <b>April 23 1957</b> on the date stated above; and to the best of my knowledge, from the causes stated. Death occurred at <b>Alton, Missouri</b>									
22a. SIGNATURE <b>W. Cooper M.D.</b> (Degree or title)				22b. ADDRESS <b>Thayer St</b>		22c. DATE SIGNED <b>4-25-57</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE <b>4-26-1957</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Hickory Grove Cemetery</b>			23d. LOCATION (City, town, or county) (State) <b>Oregon County, Missouri</b>			
24. FUNERAL DIRECTOR <b>Edward Carter</b> ADDRESS <b>Thayer St</b>				25. DATE RECD. BY LOCAL REG. <b>4/27/57</b>		26. REGISTRAR'S SIGNATURE <b>W.C. Johnson</b>			

(Licensed Embalmer's Statement on Reverse Side)

securing the medical certification of the cause of death

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 *Richard Carter* .....  
Licensed Embalmer No. *451*

P. O. Address *Hubert* .....

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.