

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

14405

STATE FILE NUMBER

FILED MAY - 9 1957

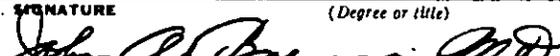
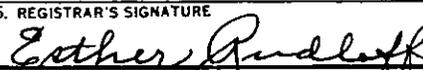
Registration District No. 316 Primary Registration District No. 6075 Registrar's No. 138

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 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 <u>St. Francois</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>St. Francois</u>			
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>St. Francois Twp.</u>		Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>		c. CITY OR TOWN <u>Farmington,</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>State Hospital No. 4</u>				Length of stay in 1b <u>- 7 mos. 1 day.</u>		d. STREET ADDRESS (If outside, give location) <u>707 Dewey</u>	
3. NAME OF DECEASED (Type or print) First <u>JESSIE</u> Middle <u>B.</u> Last <u>STEWART</u>				4. DATE OF DEATH Month <u>April</u> Day <u>24</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>December 28, 1873</u>	
9. AGE (In years last birthday) <u>83</u>		IF UNDER 1 YEAR Months <u>3</u> Days <u>26</u>		IF UNDER 24 HRS. Hours <u></u> Min. <u></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>Dade County, Missouri</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>			
13. FATHER'S NAME <u>Ben Appleby</u>				14. MOTHER'S MAIDEN NAME <u>Fine</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>Unknown</u>		17. INFORMANT <u>Records, State Hospital No. 4, Farmington, 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>Terminal pneumonia</u>							INTERVAL BETWEEN ONSET AND DEATH <u>4 das.</u>
DUE TO (b) <u>Inanition</u>							<u>abt. 1 month.</u>
DUE TO (c) <u>Psychosis with cerebral arteriosclerosis</u>							<u>abt. 1 Yr.</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Fracture of neck of left femur on 10-5-56. Osteoarthritis</u>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
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>Patient fell out of bed.</u>					
20c. TIME OF INJURY Hour <u>8:30</u> Month, Day, Year p. m. <u>10-5-56.</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>Mental Hospital ward.</u>		20f. CITY, TOWN, OR LOCATION <u>St. Francois Twp.</u>		COUNTY STATE <u>St. Francois Mo.</u>	
21. I attended the deceased from <u>Sept. 23, 1956</u> to <u>April 24, 1957</u> and last saw <u>her</u> alive on <u>April 24, 1957</u> Death occurred at <u>5:45 A. M.</u> m on the date stated above; and to the best of my knowledge, from the causes stated.							
22a. SIGNATURE 				22b. ADDRESS <u>State Hospital No. 4, Farmington, Mo.</u>		22c. DATE SIGNED <u>4-24-57.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE <u>4-26-57</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Parkview Cemetery</u>		23d. LOCATION (City, town, or county) (State) <u>Farmington, Missouri</u>	
24. FUNERAL DIRECTOR <u>Cozean Funeral Home, Farmington, Mo.</u>				ADDRESS		25. DATE RECD. BY LOCAL REG. <u>april 24-1957</u>	
26. REGISTRAR'S SIGNATURE 							

(Licensed Embalmer's Statement on Reverse Side)

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 _____
Licensed Embalmer No. 46

P. O. Address *Jurington*

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.