

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

16004

STATE FILE NUMBER

FILED APR 29 1957

372

Registration District No. Primary Registration District No. 6263

Registrar's No. 8

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 WEBSTER				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MO. b. COUNTY WEBSTER					
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN SEYMOUR RURAL FINLEY			Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	c. CITY OR TOWN RURAL FINLEY SEYMOUR		Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>			
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION			Length of stay in lb	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) GEORGE				First	Middle M.	Last FYE	4. DATE OF DEATH Month Day Year 4-2-57		
5. SEX M	6. COLOR OR RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH AUG. 24, 1885		9. AGE (In years last birthday) 71	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) FARMING			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (City and state or country) WEBSTER Co. IOWA		12. CITIZEN OF WHAT COUNTRY? U.S.A.		
13. FATHER'S NAME JAMES FYE				14. MOTHER'S MAIDEN NAME EDMONIA RECTOR					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No			16. SOCIAL SECURITY NO. no		17. INFORMANT Address MRS. GEORGE FYE SEYMOUR, MO.				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Medullary Paralysis (stroke) with INTERCEREBRAL PRESSURE DUE TO (b) Thrombotic Embolism with CEREBRAL HEMORRHAGE DUE TO (c) ARTEROSCLEROSIS PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 331X							INTERVAL BETWEEN ONSET AND DEATH 3 DAYS		
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 Month, Day, Year a. m. p. m.									
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 Jan-7-56 to 4/2/57 and last saw her alive on 4/2/57 Death occurred at 7:10 AM on the date stated above; and to the best of my knowledge, from the causes stated.									
22a. SIGNATURE J. K. Hill (Degree or title) D.O.				22b. ADDRESS Seymour			22c. DATE SIGNED 4/8/57		
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE 4-6-57	23c. NAME OF CEMETERY OR CREMATORY CARDWELL CEMETERY		23d. LOCATION (City, town, or county) WEBSTER Co. Mo.		(State)		
24. FUNERAL DIRECTOR Robert Benjamin - Seymour, Mo.			25. DATE RECD. BY LOCAL REG. 4-16-57		26. REGISTRAR'S SIGNATURE Gilbert Jones				

**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..... *Max L. Miller* .....

Licensed Embalmer No. *472*

P. O. Address *Marquette*

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.