

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

16173

STATE FILE NUMBER

FILED MAY 20 1957

Registration District No. 38 Primary Registration District No. 3006 Registrar's No. 173

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 <u>Boone</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Marion</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Columbia</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		c. CITY OR TOWN <u>Belle</u> <input checked="" type="checkbox"/> 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>University Hospital</u> Length of stay in lb <u>13 days</u>		d. STREET ADDRESS (If outside, give location) <u>Jefferson Township</u> Reside on Farm Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>Doris Marie McMaisters</u>			4. DATE OF DEATH Month Day Year <u>May 15 - 57</u>
5. SEX <u>Female</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>November 9, 1944</u>
9. AGE (In years last birthday) <u>12</u>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>school girl</u>	
10a. USUAL OCCUPATION		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and state or country) <u>Clayton, Missouri</u>
13. FATHER'S NAME <u>William Mc Maisters</u>		14. MOTHER'S MAIDEN NAME <u>Frances Conner</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>none</u>	17. INFORMANT <u>Madie Frances Conner</u> Address <u>The McMaisters Belle, Missouri</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>Chronic glomerulonephritis</u> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(n) _____			INTERVAL BETWEEN ONSET AND DEATH <u>over 1 year</u>
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> <u>2</u>		592X	
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 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 <u>May 3 1957</u> to <u>May 15, 1957</u> and last saw <u>her</u> alive on <u>May 15, 1957</u> Death occurred at <u>11:00 am</u> m on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree or title) <u>Clément E. Burke MD</u>		22b. ADDRESS <u>U. of Missouri Medical Center</u>	22c. DATE SIGNED <u>5/15/57</u>
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE <u>5-17 1957</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Pilot Knob</u>	23d. LOCATION (City, town, or county) (State) <u>Osage County, Mo</u>
24. FUNERAL DIRECTOR <u>Clyde Morton, Linn Mo</u> ADDRESS _____		25. DATE RECD. BY LOCAL REG. <u>May 16 1957</u>	26. REGISTRAR'S SIGNATURE <u>Mrs R E Palmer</u>

(Licensed Embalmer's Statement on Reverse Side)

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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 *Samuel M. Most*.....

Licensed Embalmer No. *412*

P. O. Address *Lincoln*.....

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.