

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

16353

FILED MAY 22 1957

STATE FILE NUMBER

Registration District No. 43 Primary Registration District No. 5143 Registrar's No. 351

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 <b>Butler</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Kansas</b> b. COUNTY <b>Topeka</b>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>Poplar Bluff Twsp</b> Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>		c. CITY OR TOWN <b>Topeka</b> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>Goodwill Nursing Home 5mo</b> Length of stay in lb		d. STREET ADDRESS <b>2435 Ohio St.</b> ((outside, give location) Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>CORA M. WANCE</b> First Middle Last			4. DATE OF DEATH <b>5-10-1957</b> Month Day Year
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>5-5-1873</b>
9a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Secretary</b>		9b. AGE (In years last birthday) <b>84</b>	9c. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.
10b. KIND OF BUSINESS OR INDUSTRY <b>office</b>		11. BIRTHPLACE (City and state or country) <b>Wakarusa, Kansas</b>	12. CITIZEN OF WHAT COUNTRY? <b>USA</b>
13. FATHER'S NAME <b>John W. Marsh</b>		14. MOTHER'S MAIDEN NAME <b>Callie Coberly</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b> (If yes, give war or dates of service) <b>none</b>		16. SOCIAL SECURITY NO.	
17. INFORMANT <b>Nursing Home Records</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>Arteriosclerotic Heart Disease</b> DUE TO (b) <b>Generalized Arteriosclerosis</b> DUE TO (c) <b>Sensitivity</b> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			INTERVAL BETWEEN ONSET AND DEATH <b>Unknown</b>
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		<b>4200</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.)		
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 _____ to _____ and last saw her alive on _____ Death occurred at <b>10:00p</b> m on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Doctor or title) <b>Edward W. Collins, M.D. County Health Officer</b>		22b. ADDRESS <b>Poplar Bluff, Mo.</b>	22c. DATE SIGNED <b>5/11/57</b>
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Removal</b>	23b. DATE <b>5-12-1957</b>	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION (City, town, or county) (State) <b>Topeka, Kansas</b>
24. FUNERAL DIRECTOR <b>Greer Croy &amp; Fitch</b> ADDRESS <b>Poplar Bluff, Mo.</b>	25. DATE REC'D. BY LOCAL REG. <b>5/17/57</b>	26. REGISTRAR'S SIGNATURE <b>[Signature]</b>	

(Licensed Embalmer's Statement on Reverse Side)

489-0

RECEIVED

MAY 20 1957

BUTLER CO. HEALTH CENTER

FILE No. \_\_\_\_\_

MAY 29 1957

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 *Ray P. Adams*

Licensed Embalmer No. *492*

P. O. Address *Spencer, Ohio*

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.