

Health,  
& Welfare  
Public  
Service

FILED JUN 10 1957

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

16391

STATE FILE NUMBER

Registration District No. 329 Primary Registration District No. 5773 Registrar's No. 14

S. 300  
1-57  
3

1. PLACE OF DEATH a. COUNTY <u>Callaway</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Cole</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR <u>Hill</u> TOWN <u>Rock Hill Stormont</u>		c. CITY OR TOWN <u>Jefferson City</u>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>Highway #54 North</u>		d. STREET ADDRESS (If outside, give location) <u>207 W. McCarty St.</u>	
Inside Limits <input checked="" type="checkbox"/> No <input checked="" type="checkbox"/>		Inside Limits <input checked="" type="checkbox"/> No <input type="checkbox"/>	
Length of stay in lb <u>14.5</u>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	

3. NAME OF DECEASED (Type or print) <u>Darlene Mae Tebbs</u>			4. DATE OF DEATH Month <u>May</u> Day <u>21</u> Year <u>1957</u>		
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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>Oct. 14, 1934</u>	9. AGE (In years last birthday) <u>22</u>	IF UNDER 1 YEAR Months <u>7</u> Days <u>7</u>	IF UNDER 24 HRS. Hours <u></u> Min. <u></u>
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Secretary</u>	10b. KIND OF BUSINESS OR INDUSTRY <u>Conservation Comm.</u>	11. BIRTHPLACE (City and state or country) <u>Fort Madison, Iowa</u>	12. CITIZEN OF WHAT COUNTRY? <u>USA</u>
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13a. FATHER'S NAME <u>Kyle Tebbs</u>	13b. MOTHER'S MAIDEN NAME <u>Edna Arnold</u>	14. NAME OF HUSBAND OR WIFE
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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>No</u>	17. INFORMANT <u>Mr. Kyle Tebbs</u>	Address <u>Jefferson City, Mo.</u>
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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>SKULL FRACTURE</u>		INTERVAL BETWEEN ONSET AND DEATH <u>5 MIN.</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 (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>

20a. ACCIDENT <input type="checkbox"/> SUICIDE <input checked="" 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>2 CAR Highway Collision</u>
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20c. TIME OF INJURY <u>10:30 p.m.</u> Hour <u>5</u> Month <u>5</u> Day <u>21</u> Year <u>57</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>Highway</u>	20f. CITY, TOWN, OR LOCATION <u>Callaway</u>	COUNTY <u>Mo</u> STATE <u>Mo</u>
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21. I attended the deceased from \_\_\_\_\_ to \_\_\_\_\_ and last saw her alive on \_\_\_\_\_  
Death occurred at 10:30 P. on the date stated above; and to the best of my knowledge, from the causes stated.

22a. SIGNATURE <u>Nancy A. Stewart</u>	(Degree or title) <u>Covered</u>	22b. ADDRESS <u>Fulton</u>	22c. DATE SIGNED <u>6/4/57</u>
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23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE <u>May 24, 1957</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Riverview Cemetery</u>	23d. LOCATION (City, town, or county) (State) <u>Jefferson City, Mo.</u>
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24. FUNERAL DIRECTOR'S ADDRESS <u>Victor Beacher</u>	25. DATE RECD. BY LOCAL REG. <u>June 8 - 57</u>	26. REGISTRAR'S SIGNATURE <u>Rehoy Claypool</u>
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(Licensed Embalmer's Statement on Reverse Side)

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.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

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MAY 21 1939

MS OCT 5 1939

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 *Victor Buscher*

Licensed Embalmer No. *3701*  
P. O. Address *JCma*

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.