

THE DIVISION OF HEALTH OF MISSOURI
 STANDARD CERTIFICATE OF DEATH

FILED MAY 21 1957

State File No. **16618**

BIRTH NO.		REG. DIST. NO. 99		PRIMARY REG. DIST. NO. 5377		Registrar's No. 36	
1. PLACE OF DEATH a. COUNTY DeKalb				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE Mo. b. COUNTY DeKalb ✓			
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN 4 Mi. north of Maysville		c. LENGTH OF STAY (In this place) life		c. CITY OR TOWN Maysville		d. Is Residence within limits of a city or incorporated town? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
d. FULL NAME OF HOSPITAL OR INSTITUTION				e. STREET ADDRESS (If rural, give location) 0320 4 Mile north			
3. NAME OF DECEASED (Type or Print) a. (First) Gordon b. (Middle) Randolph c. (Last) Maret			4. DATE OF DEATH Month 5 Day 9 Year 57				
5. SEX Male		6. COLOR OR RACE White		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married		8. DATE OF BIRTH 6-12-1912	
9. AGE (In years last birthday) 44		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer		10b. KIND OF BUSINESS OR INDUSTRY Farm		11. BIRTHPLACE (City and State or Foreign Country) Mo.	
12. CITIZEN OF WHAT COUNTRY? U.S.A		13a. FATHER'S NAME Joseph Maret		13b. MOTHER'S MAIDEN NAME Susan Thompson		14. NAME OF HUSBAND OR WIFE Dorothy Maret	
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 # 487-43-7438		17. INFORMANT'S SIGNATURE OR NAME ADDRESS Dorothy Maret Maysville Mo			
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) *This does not mean the mode of dying, such as heart failure, asthma, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Coronary Occlusion ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____ II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.				INTERVAL BETWEEN ONSET AND DEATH ?	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? <input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT SUICIDE HOMICIDE (Specify)		21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE) 4201			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from Coroner's Office Notified , that I last saw the deceased alive on _____, 19____, and that death occurred at Siola, Mo. , from the cause and on the date stated above.							
23a. SIGNATURE Dr. Harold Fowler				23b. ADDRESS Maysville, Mo.		23c. DATE SIGNED 5/11/57	
24a. BURIAL, CREMATION, REMOVAL (Specify) burial		24b. DATE 5-13-57		24c. NAME OF CEMETERY OR CREMATORY Fairport		24d. LOCATION (City, town, or county) (State) Fairport Mo	
DATE REC'D BY LOCAL REG. 5-18-57		REGISTRAR'S SIGNATURE Randolph		25. FUNERAL DIRECTOR'S SIGNATURE John Brown		ADDRESS Maysville Mo.	

WRITE PLAINLY—USING UNFAADING BLACK INK—MAKE A PERMANENT RECORD

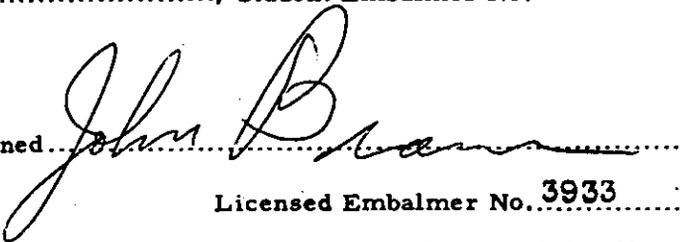
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STATEMENT BY LICENSED EMBALMER

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 .....
Licensed Embalmer No. 3933

P. O. Address Maysville Mo.....

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.