

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

16899

FILED JUN 13 1957

STATE FILE NUMBER

Registration District No. 144 Primary Registration District No. 4234 Registrar's No. 44

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 causally 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>xStxxMx Iron</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Mo.</u> b. COUNTY <u>Reynolds</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Ironton, Mo.</u> Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>		c. CITY OR TOWN <u>LESTERVILLE</u> Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>St. Marys</u> Length of stay in 1b		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) <u>Mary</u> <i>First</i> <u>Elizabeth</u> <i>Middle</i> <u>Liebi</u> <i>Last</i>		4. DATE OF DEATH <u>June 2 1957</u> <i>Month Day Year</i>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>June 27 1892</u> <i>Month Day Year</i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Home</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Housewife</u>	9. AGE (In years at birthday) <u>64</u> IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.
11. BIRTHPLACE (City and state or country) <u>Lesterville, Mo</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>James Faulkenberry</u>		14. MOTHER'S MAIDEN NAME <u>Martha Welch</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.	
17. INFORMANT <u>Christian Leibe</u> Address <u>Lesterville, Mo.</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>Cerebral hemorrhage</u> DUE TO (b) <u>Acute hypertension</u> DUE TO (c) <u>hemiplegia (left)</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(n) <u>331x</u>			INTERVAL BETWEEN ONSET AND DEATH <u>4</u> days  <u>?</u>  <u>4</u> 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.)		
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>5-30-57</u> to <u>6-2-57</u> and last saw her <del>him</del> alive on <u>6-2-57</u> Death occurred at <u>5:30 P. M.</u> on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE <u>R. E. Jarland, M.D.</u> (Name or title)		22b. ADDRESS <u>Shronton, Mo.</u>	
22c. DATE SIGNED <u>6/5/57</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	23b. DATE <u>JUNE 5, 1957</u>	23c. NAME OF CEMETERY OR CREMATORY <u>MASONIC</u>	23d. LOCATION (City, town, or county) (State) <u>LESTERVILLE Mo</u>
24. FUNERAL DIRECTOR ADDRESS <u>WHITE FUNERAL HOME Ironton</u>		25. DATE RECD. BY LOCAL REG. <u>6-6-57</u>	26. REGISTRAR'S SIGNATURE <u>Miss Aris Jones</u>
(Licensed Embalmer's Statement on Reverse Side) <u>Arnell Welch</u>			

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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..... *[Signature]*

Licensed Embalmer No. 429

P. O. Address *[Address]*

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (F 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.