

Health,
Welfare
Public
Service

300
1-56
0020

ALL
diseases in Part I must be causally related. Coroner cannot certify to a death due to natural causes. Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed. All

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

19933

STATE FILE NUMBER

FILED JUN 19 1957

Registration District No. 2 Primary Registration District No. 4009 Registrar's No. 36

1. PLACE OF DEATH a. COUNTY <u>Andrew</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Andrew</u>			
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>SAVANNAH</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		c. CITY OR TOWN <u>SAVANNAH</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION			Length of stay in lb <u>60 yrs</u>		d. STREET ADDRESS (If outside, give location) <u>1102 W. Chestnut</u>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <u>Josephine</u> Middle _____ Last <u>Allen</u>				4. DATE OF DEATH Month <u>6</u> Day <u>13</u> Year <u>1957</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH <u>11-9-1868</u>	9. AGE (In years last birthday) <u>89</u>	IF UNDER 1 YEAR Months _____ Days _____	IF UNDER 24 HRS. Hours _____ Min. _____	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>At Home</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>At Home</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (City and state or country) <u>Dominaton Ohio</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>John Jessup</u>				14. MOTHER'S MAIDEN NAME <u>Elizabeth Locke</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yrs. give war or dates of service) <u>no</u>		16. SOCIAL SECURITY NO. <u>no</u>		17. INFORMANT Address <u>John Allen 1102 W. Chestnut</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>Cardiac attrial fibrillation</u> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. } DUE TO (b) <u>Myocardial infarction</u> DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (n) <u>4331</u>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> <u>2</u>				INTERVAL BETWEEN ONSET AND DEATH <u>1 year</u> <u>1 hour</u>			
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 _____ a. m. _____ p. m. Month, Day, Year.							
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>February 27, 1956</u> <u>6-13-57</u> and last saw her ^{her} _{alive} on <u>6-13-57</u> Death occurred at _____ m on the date stated above; and to the best of my knowledge, from the causes stated.							
22a. SIGNATURE (Degree or title) <u>Albert B. Kelly</u>				22b. ADDRESS <u>Savannah, Missouri</u>		22c. DATE SIGNED <u>6-15-57</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE <u>6-16-1957</u>	23c. NAME OF CEMETERY OR CREMATORY <u>SAVANNAH</u>		23d. LOCATION (City, town, or county) (State) <u>SAVANNAH MO</u>			
24. FUNERAL DIRECTOR <u>Breit Funeral Home</u>			ADDRESS <u>Savannah Mo</u>		25. DATE RECD. BY LOCAL REG. <u>6-16-57</u>	26. REGISTRAR'S SIGNATURE <u>William Sparks</u>	

(Licensed Embalmer's Statement on Reverse Side)

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 *E. C. Breit*.....

Licensed Embalmer No. *26*

P. O. Address *Jacobs*

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