

Health,
Welfare,
Public
Service

300
-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

FILED JUL 11 1957

STANDARD CERTIFICATE OF DEATH

19534

STATE FILE NUMBER

Registration District No. 2 Primary Registration District No. 400 Registrar's No. 40

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>Bolckow</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <u>Bolckow</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 ^{1b}	8020 STREET (If outside, give location) ADDRESS		Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) <u>MARGRETE ESTES BEDFORD</u> <small>First Middle Last</small>			4. DATE OF DEATH <u>7-3-1957</u> <small>Month Day Year</small>		
5. SEX <u>Female</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Nov 18 1896</u>	9. AGE (In years last birthday) <u>76</u> IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
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>Cocoma Ind.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>
13. FATHER'S NAME <u>Lodiska Williams</u>			14. MOTHER'S MAIDEN NAME <u>UNKNOWN</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. <u>no</u>	17. INFORMANT <u>A.L. Bedford</u> Address <u>Bolckow 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>pulmonary Tuberculosis</u>					INTERVAL BETWEEN ONSET AND DEATH <u>20 yrs</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) <u>002X</u>					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> <u>2</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>2-15-1940</u> to <u>7-3-1957</u> and last saw her/him alive on <u>7-1-1957</u> Death occurred at <u>9:30</u> <u>A</u> m on the date stated above; and to the best of my knowledge, from the causes stated.					
22a. SIGNATURE <u>Dr. R. B. Wilson M.D.</u> (Degree or title)			22b. ADDRESS <u>Rosendale Mo</u>		22c. DATE SIGNED <u>7-4-1957</u>
23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE <u>7-5-1957</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Bolckow</u>		23d. LOCATION (City, town, or county) (State) <u>Bolckow Mo</u>	
24. FUNERAL DIRECTOR <u>Breit Funeral Home Savannah Mo</u> ADDRESS		25. DATE RECD. BY LOCAL REG. <u>7-5-57</u>		26. REGISTRAR'S SIGNATURE <u>William Sparks</u>	

(Licensed Embalmer's Statement on Reverse Side)

WINDY 1959

AUG 20 1957

AUG 7 1957

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was em
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 *Savannah*

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.