

Health, Welfare & Public Service

300
1-56

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.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

FILED JUL 8 1957

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

19936
STATE FILE NUMBER

Registration District No. 2 Primary Registration District No. 4009 Registrar's No. 37

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 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 <u>407 S Hickory Drive</u>			Length of stay in 1b <u>9020</u>		d. STREET ADDRESS (If outside, give location) <u>407 S Hickory Drive</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 <u>CLARK</u> Last <u>CLARK</u>				4. DATE OF DEATH Month <u>6</u> Day <u>21</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"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>2-6-1873</u>		9. AGE (in years last birthday) <u>84</u>	IF UNDER 1 YEAR Months <u>0</u> Days <u>0</u> Hours <u>0</u> Min. <u>0</u>	IF UNDER 24 HRS. Hours <u>0</u> Min. <u>0</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>ANDREW Co. Mo.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>		
13. FATHER'S NAME <u>JOHN WESLEY POPPLEWELL</u>				14. MOTHER'S MAIDEN NAME <u>MARY JANE ALLEN</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>Mrs. Winford W. Bailey Savannah</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-Vascular-Accident</u>							INTERVAL BETWEEN ONSET AND DEATH <u>7 days.</u>		
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <u>Probable Cerebral Emboli</u>							<u>7 days.</u>		
DUE TO (c) <u>Atrial Fibrillation</u>							<u>10 days.</u>		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>H33.1</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 <u> </u> Month, Day, Year a. m. <u> </u> p. m. <u> </u>									
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>5-13-57</u> to <u>6-21-57</u> and last saw <u>her</u> alive on <u>6-21-57</u> Death occurred at <u> </u> m on the date stated above; and to the best of my knowledge, from the causes stated.									
22a. SIGNATURE (Degree or title) <u>Lillian B. Kellum M.D.</u>				22b. ADDRESS <u>Savannah, Missouri</u>			22c. DATE SIGNED <u>6-24-57</u>		
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE <u>6-24-1957</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Whitesville</u>		23d. LOCATION (City, town, or county) (State) <u>Whitesville Mo</u>				
24. FUNERAL DIRECTOR <u>Breit Funeral Home SAVANNAH MO</u>				ADDRESS <u> </u>		25. DATE RECD. BY LOCAL REG. <u>6-27-57</u>		26. REGISTRAR'S SIGNATURE <u>Kellum 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 *Lawrence*

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