

Health,  
Welfare  
Public  
Service

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

20255

STATE FILE NUMBER

FILED JUN 18 1957

Registration District No. 47 Primary Registration District No. 3008 Registrar's No. 150

300  
-573  
143

1. PLACE OF DEATH a. COUNTY <u>Callaway</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Mo.</u> b. COUNTY <u>Callaway</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Fulton</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <u>Fulton</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>Callaway Hospital</u>		Length of stay in lb <u>80 Days</u>	d. STREET ADDRESS (If outside, give location) <u>818 Jefferson</u> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <u>Lillie</u> Middle <u>Elnora</u> Last <u>Bezler</u>			4. DATE OF DEATH Month <u>June</u> Day <u>8</u> Year <u>1957</u>
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>Feb. 14, 1884</u>
9. AGE (In years last birthday) <u>73</u>		IF UNDER 1 YEAR Months _____ Days _____	IF UNDER 24 HRS. Hours _____ Min. _____
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Housework</u>	11. BIRTHPLACE (City and state or country) <u>Callaway Co. Mo.</u>
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13a. FATHER'S NAME <u>Joseph Cepicky</u>	
13b. MOTHER'S MAIDEN NAME <u>Mary Maydell</u>		14. NAME OF HUSBAND OR WIFE <u>M.E. Bezler</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>None</u>	17. INFORMANT <u>M.E. Bezler</u> Address <u>818 Jefferson Fulton</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 Disease c.</u> <u>Nephrosclerosis and totemia</u> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. } DUE TO (b) <u>Gen. arteriosclerosis.</u> DUE TO (c) <u>Diabetes Mellitus</u>			INTERVAL BETWEEN ONSET AND DEATH <u>1 month</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>260X</u>			19. WAS AUTOPSY PERFORMED? <u>2</u> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
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 <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>5/28/57</u> to <u>6/8/57</u> and last saw her alive on <u>6/8/57</u> - Death occurred at <u>10:05 p</u> m on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE <u>George Wood</u> (Degree or title) <u>no</u>		22b. ADDRESS <u>Fulton Mo</u>	22c. DATE SIGNED <u>6/15/57</u>
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE <u>June 11, 1957</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Hillcrest</u>	23d. LOCATION (City, town, or county) (State) <u>Fulton Mo.</u>
24. FUNERAL DIRECTOR <u>Glen Y. Maupin</u> ADDRESS <u>Fulton Mo.</u>		25. DATE RECD. BY LOCAL REG. <u>Jan. 15-1957</u>	26. REGISTRAR'S SIGNATURE <u>Maretha Lawrence</u>

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE  
MEDICAL CERTIFICATION

All diseases in Part I must be causally related.  
Doctor, coroner, etc. must use only standard nomenclature in Part II. No symptoms will be stated.

(Licensed Embalmer's Statement on Reverse Side)

JUL 3 1959

NOV 18 1959 SA

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 *J. A. Rossor* .....

Licensed Embalmer No. *2555* .....  
P. O. Address *Fullon m* .....

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.