

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

2063

STATE FILE NUMBER

FILED JUN 18 1957

Registration District No. 47 Primary Registration District No. 3008 Registrar's No. 147

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| 1. PLACE OF DEATH a. COUNTY <u>CALLAWAY</u> | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MISSOURI</u> b. COUNTY <u>LINCOLN</u> | |
| b. CITY (If outside corporate limits, give TOWNSHIP only) Inside Limits OR TOWN <u>FULTON</u> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> | | c. CITY OR TOWN <u>TROY</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> | |
| c. FULL NAME OF (If NOT in hospital, give location) Length of stay in lb HOSPITAL OR INSTITUTION <u>STATE HOSPITAL #1</u> <u>12 YRS.</u> | | d. STREET ADDRESS (If outside, give location) Reside on Farm <u>6570</u> Yes <input type="checkbox"/> No <input type="checkbox"/> | |

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| 3. NAME OF DECEASED (Type or print) <u>MARTHA CZESCHIN</u> First Middle Last | | | 4. DATE OF DEATH <u>JUNE 11, 1957</u> Month Day Year | | |
| 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"/> SEPARATED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>2-3-84</u> | 9. AGE (In years last birthday) <u>73</u> | IF UNDER 1 YEAR Months Days Hours Min. |

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| 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>HOME</u> | 11. BIRTHPLACE (City and state or country) <u>MISSOURI</u> | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u> |
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| 13. FATHER'S NAME <u>JAMES THOMAS GIBSON</u> | 14. MOTHER'S MAIDEN NAME <u>SARAH E. BUFFORD</u> |
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| 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 Address <u>STATE HOSPITAL #1, FULTON, MISSOURI</u> |
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| 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>PYELONEPHRITIS</u> | | INTERVAL BETWEEN ONSET AND DEATH |
| Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. | DUE TO (b) <u>GENERALIZED ARTERIOSCLEROSIS</u> | |
| | DUE TO (c) <u>DECUBITIS ULCERATION OF THE BACK</u> | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>6000</u> | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> <u>2</u> |

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| 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. | |

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| 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 |
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21. X STATE HOSPITAL #1 attended the deceased from 12-12-45 to 6-11-57
Death occurred at 9:55 a.m. m on the date stated above; and to the best of my knowledge, from the causes stated.

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| 22a. SIGNATURE (Degree or title) <u>R.C. ROBERTSON, M.D.</u> | 22b. ADDRESS <u>STATE HOSPITAL #1, FULTON, MO.</u> | 22c. DATE SIGNED <u>6-11-57</u> |
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| 23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u> | 23b. DATE <u>6/14/57</u> | 23c. NAME OF CEMETERY OR CREMATORY <u>TROY CEMETERY</u> | 23d. LOCATION (City, town, or county) (State) <u>TROY, MO</u> |
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| 24. FUNERAL DIRECTOR <u>HENDER-MATSH TROY, MO</u> | 25. DATE RECD. BY LOCAL REG. <u>June 11-1957</u> | 26. REGISTRAR'S SIGNATURE <u>Maretha Lawrence</u> |
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(Licensed Embalmer's Statement on Reverse Side)

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

Doctor, coroner, etc. must use only standard nomenclature in reporting the symptoms and diseases in Part I must be casually related. Coroner cannot certify to a death due to natural causes.

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.....

Joseph J. Mann

Licensed Embalmer No. 39

P. O. Address Troy, N.Y.

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.