

Health,  
Welfare  
Public  
Service

300  
-57

All diseases in Part I must be causally related.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE  
MEDICAL CERTIFICATION

FILED JUL 16 1957

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

23781

STATE FILE NUMBER

Registration District No. 47 Primary Registration District No. 5157 Registrar's No. 175

1. PLACE OF DEATH a. COUNTY <u>Callaway</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>Jan 9, 1884</u>		9. AGE (In years last birthday) <u>73</u>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>housewife</u>		11. BIRTHPLACE (City and state or country) <u>Callaway County Mo</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>			
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Auxvasse Twp.</u>		Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>		c. CITY OR TOWN <u>Auxvasse Twp.</u>		Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>		d. STREET ADDRESS <u>RFD Portland</u>		(If outside, give location) <u>Reside on Farm</u>		Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		c. FULL NAME OF (IF NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>Rfd Portland</u>		Length of stay in 1b <u>20 yrs</u>			
3. NAME OF DECEASED (Type or print) First <u>Lillie</u> Middle <u>Effie</u> Last <u>Masek</u>				4. DATE OF DEATH <u>July 6, 1957</u>				13a. FATHER'S NAME <u>John Masek</u>		13b. MOTHER'S MAIDEN NAME <u>Elizabeth unknown</u>		14. NAME OF HUSBAND OR WIFE <u>John Masek</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>Clarence Masek</u> Address <u>Portland 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>Cerebral Hemorrhage</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>Cardio-vascular Hypertension</u>																			
DUE TO (c) <u>443x</u>												19. WAS AUTOPSY PERFORMED? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)																			
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 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>April - 1957</u> to <u>July 6 - 1957</u> and last saw her alive on <u>June 26 - 1957</u> Death occurred at <u>5:15 P</u> on the date stated above; and to the best of my knowledge, from the causes stated.																			
22a. SIGNATURE <u>W. Lawrence</u> (Degree or title)												22b. ADDRESS <u>R#3 Fulton Mo</u>			22c. DATE SIGNED <u>7-10-57</u>				
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>			23b. DATE <u>July 9, 1957</u>			23c. NAME OF CEMETERY OR CREMATORY <u>Portland</u>			23d. LOCATION (City, town, or county) (State) <u>Portland Mo.</u>										
24. FUNERAL DIRECTOR <u>Maryann Funch</u> ADDRESS <u>Fulton Mo</u>						25. DATE RECD. BY LOCAL REG. <u>July-13-1957</u>			26. REGISTRAR'S SIGNATURE <u>Maretha Lawrence</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 *J. J. Passon* .....  
Licensed Embalmer No. *2555* .....  
P. O. Address *Auton* .....

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.