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FILED JUL 23 1957

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

24360
STATE FILE NUMBER

Registration District No. 143 Primary Registration District No. 4557 Registrar's No.

1. PLACE OF DEATH a. COUNTY <u>Howell</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Howell</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Pomona,</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <u>Pomona,</u>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>X</u> <u>X</u>		Length of stay in 1b <u>20 yrs</u>	d. STREET ADDRESS (If outside, give location) <u>X</u>
			Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print) First Middle Last <u>Mary Edna Halstead</u>			4. DATE OF DEATH Month Day Year <u>7-13-57</u>		
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</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>7-26-1889</u>	9. AGE (In years last birthday) <u>67</u>	IF UNDER 1 YEAR Months <u>11</u> Days <u>16</u>
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>X</u> <u>X</u>	11. BIRTHPLACE (City and state or country) <u>Crooked Tree, Ohio</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>
13a. FATHER'S NAME <u>G. H. Nichols</u>		13b. MOTHER'S MAIDEN NAME <u>Anna Gessel</u>		14. NAME OF HUSBAND OR WIFE <u>Geo. E. Halstead</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war & dates of service) <u>X</u>		16. SOCIAL SECURITY NO. <u>X</u>		17. INFORMANT <u>G. E. Halstead, Pomona, 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 edema</u>			INTERVAL BETWEEN ONSET AND DEATH <u>2 days</u>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) <u>Arteriosclerotic heart disease</u>		
	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>Cerebral Thrombosis</u>			19. WAS AUTOPSY PERFORMED? 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 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 <u>West Plains</u>	
				COUNTY <u>West Plains</u>	
				STATE <u>Mo</u>	
21. I attended the deceased from <u>5/19/57</u> to <u>7/13/57</u> and last saw her <u>alive</u> on <u>7/12/57</u> Death occurred at <u>5:00 AM</u> on the date stated above; and to the best of my knowledge, from the causes stated.					
22a. SIGNATURE (Degree or title) <u>M. L. Fowler M.D.</u>			22b. ADDRESS <u>West Plains</u>		22c. DATE SIGNED <u>7/16/57</u>

23a. BURIAL, CREMATION, REMOVAL (Specify) <u>B</u>		23b. DATE <u>7-14-57</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Oak Lawn Cemetery</u>	23d. LOCATION (City, town, or county) (State) <u>West Plains, Mo</u>	
24. FUNERAL DIRECTOR <u>Robertsons, West Plains, Mo</u>			25. DATE RECD. BY LOCAL REG. <u>7-23-57</u>	26. REGISTRAR'S SIGNATURE <u>Tom Durdon, acting Dir.</u>	

(Licensed Embelmer's Statement on Reverse Side)

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

FEB 26 1958

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. S. Roberts

Licensed Embalmer No. *3470*

P. O. Address *1111 17th St*

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.