

FILED AUG 14 1957

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

255885

STATE FILE NUMBER

Registration District No. 278 Primary Registration District No. 3054 Registrar's No. 91

1. PLACE OF DEATH a. COUNTY <b>Pike</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Missouri</b> b. COUNTY <b>Pike</b>				
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>Louisiana</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		c. CITY OR TOWN <b>Louisiana</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>Pike Co. Hospital</b>		Length of stay in lb <b>2 months</b>		d. STREET ADDRESS <b>220 North 14th</b> (If outside, give location)		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print)			First Middle Last			4. DATE OF DEATH		
<b>ELIZABETH</b>			<b>FRANCES</b>			<b>FINDLY</b>		
5. SEX <b>Female</b>			6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>Nov. 19, 1858</b>	
9. AGE (In years last birthday) <b>98</b>		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.				
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>			10b. KIND OF BUSINESS OR INDUSTRY <b>Housekeeping</b>		11. BIRTHPLACE (City and state or country) <b>St. Louis, Mo.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S.</b>	
13. FATHER'S NAME <b>Frank Botwars</b>				14. MOTHER'S MAIDEN NAME <b>Cathrine Hoffmann</b>				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>NO</b>		16. SOCIAL SECURITY NO. <b>None</b>		17. INFORMANT Address <b>Mrs. Clarence Tully, Louisiana, Mo.</b>				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral vascular accident.</b>							INTERVAL BETWEEN ONSET AND DEATH <b>7 1/2 weeks</b>	
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.								
DUE TO (b) <b>Arteriosclerosis Hypertensive Cardio-Vascular</b>							10 yrs plus	
DUE TO (c) <b>Senility</b>							10 yrs plus	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> <b>2</b>	
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.) <b>_____</b>					
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.) <b>_____</b>			20f. CITY, TOWN, OR LOCATION <b>_____</b>		COUNTY <b>_____</b>		STATE <b>_____</b>	
21. I attended the deceased from <b>7-12-54</b> to <b>7-30-57</b> and last saw her <sup>alive</sup> on <b>7-30-57</b> Death occurred at <b>5:30 p</b> m on the date stated above; and to the best of my knowledge, from the causes stated.								
22a. SIGNATURE (Degree or title) <b>Chas. N. Pullen M.D.</b>					22b. ADDRESS <b>Louisiana, Missouri</b>		22c. DATE SIGNED <b>7-31-57</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City, town, or county) (State)		
<b>Burial</b>		<b>8/1/57</b>		<b>Riverview Cemetery</b>		<b>Louisiana, Mo.</b>		
24. FUNERAL DIRECTOR ADDRESS <b>Sterna Funeral Home, Louisiana, Mo.</b>				25. DATE RECD. BY LOCAL REG. <b>July 31, 1957</b>		26. REGISTRAR'S SIGNATURE <b>Bernice Collier</b>		

(Licensed Embalmer's Statement on Reverse Side)

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

Diseases in Part I must be causally related. Coroner cannot certify to a death due to natural causes. All symptoms must be listed. No symptoms will be listed. All

300  
-56Health,  
Welfare  
Public  
Service  
91

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 *Virginia M. Stern*.....

Licensed Embalmer No. *464*

P. O. Address *Louisiana*

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.