

Health,
Welfare
Public
Service

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

27256

STATE FILE NUMBER

FILED AUG 6 1957

Registration District No. 360 Primary Registration District No. 3076 Registrar's No. 139

300
1-56

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

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

| | | | |
|---|--|--|---|
| 1. PLACE OF DEATH a. COUNTY <u>Vernon</u> | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Mo.</u> COUNTY <u>Vernon</u> | |
| b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Nevada - Bluemound</u> Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/> | | c. CITY OR TOWN <u>Harwood</u> Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> | |
| c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>Nevada City Hos</u> Length of stay in lb <u>two wks.</u> | | d. STREET ADDRESS (If outside, give location) <u>R#1 Harwood</u> Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) First <u>Edna</u> Middle <u>Elizabeth</u> Last <u>True</u> | | | 4. DATE OF DEATH Month <u>July</u> Day <u>24</u> Year <u>1957</u> |
| 5. SEX <u>F</u> | 6. COLOR OR RACE <u>W</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>Dec. 11, 1879</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>House work</u> | 9. AGE (In years last birthday) <u>77</u> IF UNDER 1 YEAR: Months <u>11</u> Days <u>24</u> Hours <u>19</u> Min. <u>57</u> |
| 11. BIRTHPLACE (City and state or country) <u>Rantoul Illinois</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u> | |
| 13. FATHER'S NAME <u>John Davis</u> | | 14. MOTHER'S MAIDEN NAME <u>Ida Amanda McMaster</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>Mrs. Leland Arnold, Schell City,</u> | | Address <u>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>Congestive Heart Failure</u> | | | INTERVAL BETWEEN ONSET AND DEATH <u>10 days</u> |
| Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <u>Hypertensive Cardio Vascular Disease</u> | | | <u>20 yrs.</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>Uremia</u> | | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> <u>2</u> |
| 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.) <u>443X</u> | | |
| 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>July 22, 1955</u> to <u>July 24, 1957</u> , and last saw her/him alive on <u>July 24, 1957</u> . Death occurred at <u>Nevada, Mo. 5:55 P</u> m on the date stated above; and to the best of my knowledge, from the causes stated. | | | |
| 22a. SIGNATURE <u>L. P. McCann, M. D.</u> | | 22b. ADDRESS <u>Moore Bldg., Nevada, Mo.</u> | 22c. DATE SIGNED <u>7-29-57</u> |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | 23b. DATE <u>7/27/1957</u> | 23c. NAME OF CEMETERY OR CREMATORY <u>Schell City</u> | 23d. LOCATION (City, town, or county) (State) <u>Schell City, Mo.</u> |
| 24. FUNERAL DIRECTOR <u>O. W. Waggoner, Harwood, Mo.</u> | | 25. DATE RECD. BY LOCAL REG. <u>7-30-1957</u> | 26. REGISTRAR'S SIGNATURE <u>Anna E. Ferry</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..... *O. W. Waggoner*.....
Licensed Embalmer No. 2709

P. O. Address Harwood, N

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.