

Health,
Welfare
Public
Service

300
1-56

Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed. All diseases in Part I must be causally related. Coroner cannot certify to a death due to natural causes.

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

FILED AUG 13 1957

27303

STATE FILE NUMBER

Registration District No. 370 Primary Registration District No. 6258 Registrar's No. 76

1. PLACE OF DEATH a. COUNTY <u>Wayne</u>				2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Wayne</u>			
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Silva</u>		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>		c. CITY OR TOWN <u>Silva</u>		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION			Length of stay in 1b	d. STREET ADDRESS (If outside, give location)			Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <u>William</u> Middle <u>T.</u> Last <u>Levart</u>				4. DATE OF DEATH Month <u>7</u> Day <u>24</u> Year <u>57</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</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>7-4-1874</u>	9. AGE (In years last birthday) <u>83</u>	IF UNDER 1 YEAR Months <u>20</u> Days <u>20</u> Hours <u> </u> Min. <u> </u>	IF UNDER 24 HRS. Hours <u> </u> Min. <u> </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>FARMING</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>Farm</u>		11. BIRTHPLACE (City and state or country) <u>Greenville, Mo.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>
13. FATHER'S NAME (Foster) <u>Irvin Cooper</u>				14. MOTHER'S MAIDEN NAME (Foster) <u>Mary Cooper</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <input checked="" type="checkbox"/>		16. SOCIAL SECURITY NO. <u>-</u>		17. INFORMANT <u>Cora Bell Levart</u>		Address <u>Silva, 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>aortic stenosis</u>							INTERVAL BETWEEN ONSET AND DEATH <u>1 yr.</u>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.							DUE TO (b) _____
DUE TO (c) _____							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"/>							<u>4211</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.)				
20c. TIME OF INJURY Hour _____ 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>Sept 1946</u> , to <u>July 1957</u> and last saw her/him alive on <u>7-22-57</u> Death occurred at _____ m on the date stated above; and to the best of my knowledge, from the causes stated.							
22a. SIGNATURE (Degree or title) <u>O.A. Meyer, M.D.</u>				22b. ADDRESS <u>Coldwater, Mo.</u>		22c. DATE SIGNED <u>7-24-57</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE <u>7-27-57</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Bounds Creek Cem near Silva</u>		23d. LOCATION (City, town, or county) (State) <u>Silva, Mo</u>		
24. FUNERAL DIRECTOR <u>Norman H. Bish</u>				ADDRESS <u>Prescott, Mo</u>		25. DATE RECD. BY LOCAL REG. <u>8-9-1957</u>	26. REGISTRAR'S SIGNATURE <u>Bretta M. Way</u>

(Licensed Embalmer's Statement on Reverse Side)

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

RECEIVED
AUG 9 1957
WAYNE CO. HEALTH CENTER
FILE NO.

AUG 8 8 1957

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 *Ferman W. G...*

Licensed Embalmer No. *330*

P. O. Address *Piedmont*

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.