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FILED SEP 9 1957

THE DIVISION OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

'57 027670
STATE FILE NUMBER

Registration District No. 47 Primary Registration District No. 3008 Registrar's No. 213

1. PLACE OF DEATH
a. COUNTY: CALLAWAY
b. CITY OR TOWN (If outside corporate limits, give TOWNSHIP only): Fulton — Inside Limits: Yes [X] No [ ]
c. FULL NAME OF HOSPITAL OR INSTITUTION (If NOT in hospital, give location): State Hospital No.1 — Length of stay in 1b: 55 years

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Missouri b. COUNTY: Audrain
c. CITY OR TOWN: Mexico — Inside Limits: Yes [ ] No [ ]
d. STREET ADDRESS (If outside, give location): — Reside on Farm: Yes [ ] No [ ]

3. NAME OF DECEASED (Type or print): First: GERTRUDE Middle: Last: PRESTON

4. DATE OF DEATH: Month SEPTEMBER Day 6, Year 1957

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED [ ] NEVER MARRIED [X] WIDOWED [ ] DIVORCED [ ]

8. DATE OF BIRTH: Approx. 1886

9. AGE (In years last birthday): 71 ? — IF UNDER 1 YEAR: Months, Days — IF UNDER 24 HRS.: Hours, Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): None

10b. KIND OF BUSINESS OR INDUSTRY: —

11. BIRTHPLACE (City and state or country): unk.

12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13a. FATHER'S NAME: unk.

13b. MOTHER'S MAIDEN NAME: Mrs. Edith Preston

14. NAME OF HUSBAND OR WIFE: None

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.: None

17. INFORMANT Address: State Hospital No. 1; Fulton, Mo.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Arteriosclerotic Heart Disease
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) Generalized Arteriosclerosis
DUE TO (c)
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) 4 200

INTERVAL BETWEEN ONSET AND DEATH

19. WAS AUTOPSY PERFORMED? YES [ ] NO [X]

20a. ACCIDENT [ ] SUICIDE [ ] HOMICIDE [ ]

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. Month, Day, Year

20d. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]

20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

20f. CITY, TOWN, OR LOCATION COUNTY STATE

St. Hosp. #1

21. I attended the deceased from 10-19-1902, to 9-6-1957 and last saw her/him alive on 9-6-57
Death occurred at 6:15 a.m. on the date stated above; and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or Title): Douglas Romney M.D. Douglas Romney, M.D.

22b. ADDRESS: State Hospital No. 1; Fulton, Missouri

22c. DATE SIGNED: 9-6-1957

23a. BURIAL, CREMATION, REMOVAL (Specify)

23b. DATE: 9/6/57

23c. NAME OF CEMETERY OR CREMATORY: Anatomical Board

23d. LOCATION (City, town, or county): Columbia (State): Mo

24. FUNERAL DIRECTOR: Robert D. Johnston — ADDRESS: Columbia, Mo.

25. DATE RECD. BY LOCAL REG.: Sept. 6-1957

26. REGISTRAR'S SIGNATURE: Maretta Lawrence

(Licensed Embalmer's Statement on Reverse Side)

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

All diseases in Part I must be causally related.

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 ..... Signed .....
Signature of Student Embalmer

Licensed Embalmer No. .....

P. O. Address .....

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.