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USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

ALL diseases in Part I must be causally related.

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FILED SEP 13 1957

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

STATE FILE NUMBER

Registration District No. 96 Primary Registration District No. 5353 Registrar's No. 76

1. PLACE OF DEATH a. COUNTY <u>Dallas</u>				2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Dallas</u>			
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Jackson Twp.</u>		Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>		c. CITY OR TOWN <u>Elkland</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>Residence</u>		Length of stay in lb <u>life</u>		d. STREET ADDRESS (If outside, give location) <u>RFD #2</u>		Reside on Farm Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>FRONA</u> Middle <u>WINGO</u> Last				4. DATE OF DEATH Month <u>Aug.</u> Day <u>17</u> Year <u>1957</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Oct. 18, 1880</u>		9. AGE (In years or birthday) <u>76</u>	IF UNDER 1 YEAR Months <u>0</u> Days <u>0</u>	IF UNDER 24 HRS. Hours <u>0</u> Min. <u>0</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, or when retired) <u>House wife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>own house</u>		11. BIRTHPLACE (City and state or country) <u>Dallas County</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13a. FATHER'S NAME <u>Joseph Davison</u>		13b. MOTHER'S MAIDEN NAME <u>Nancy Cooksey</u>		14. NAME OF HUSBAND OR WIFE <u>Deceased</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>—</u>		17. INFORMANT Address <u>Lena M. Cashin Buffalo, 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>Coronary thrombosis</u> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <u>Hypertension</u> DUE TO (c) <u>Arteriosclerosis</u>						INTERVAL BETWEEN ONSET AND DEATH <u>4 days</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>Obesity</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 <u>2:02</u> Month <u>8</u> Day <u>17</u> Year <u>1957</u> 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>1946</u> to <u>8-17-57</u> and last saw her alive on <u>8-14-57</u> Death occurred at <u>2:02</u> m on the date stated above; and to the best of my knowledge, from the causes stated.							
22a. SIGNATURE <u>P. O. Jammon MD.</u> (Degree or title)				22b. ADDRESS <u>Buffalo Mo.</u>		22c. DATE SIGNED <u>8-19-57</u>	
23a. BURIAL, CREMATION, OR REMOVAL (Specify)		23b. DATE <u>8-19-57</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Macedonia</u>		23d. LOCATION (City, town, or county) (State) <u>Buffalo, Mo.</u>		
24. FUNERAL DIRECTOR <u>Jones of Buffalo, Mo.</u> ADDRESS				25. DATE RECD. BY LOCAL REG. <u>9/2/57</u>		26. REGISTRAR'S SIGNATURE <u>Mrs. Irene Petree</u>	

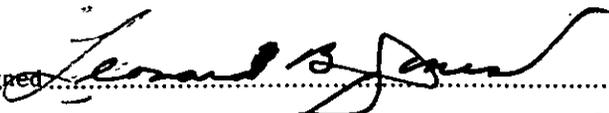
(Licensed Embalmer's Statement on Reverse Side)

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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 

Licensed Embalmer No. 2508
P. O. Address Buffalo

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.