

Health,
Welfare
Public
Service

FILED SEP 9 1957

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

28078

STATE FILE NUMBER

Registration District No. 128 Primary Registration District No. 5458 Registrar's No. 852

1. PLACE OF DEATH a. COUNTY <u>Greene</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Greene</u>			
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Walnut Grove Township</u>		Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>		c. CITY OR TOWN <u>Walnut Grove</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>2 Mi. So. Walnut Grove</u>		Length of stay in 1b		d. STREET ADDRESS (If outside, give location) <u>Rt 2 2 Mi. So. Walnut Grove</u>		Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Elmer</u> Middle <u>William</u> Last <u>Emery</u>			4. DATE OF DEATH Month <u>Aug</u> Day <u>29</u> Year <u>1957</u>				
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</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>April 1 - 1884</u>		9. AGE (In years If UNDER 1 YEAR If UNDER 24 HRS. Last birthday) <u>71</u> Months <u>7</u> Days <u>1</u> Hours <u>0</u> Min. <u>0</u>		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Framer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Retired</u>		11. BIRTHPLACE (City and state or country) <u>Clinton Missouri</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13a. FATHER'S NAME <u>Sam</u>		13b. MOTHER'S MAIDEN NAME <u>Addie Sapp</u>		14. NAME OF HUSBAND OR WIFE <u>Minnie Emery</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>493-16-9118</u>		17. INFORMANT <u>Minnie Emery Rt 2 Walnut Grove</u> Address			
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>Suspected malignancy of Bladder (Urinary)</u>						INTERVAL BETWEEN ONSET AND DEATH <u>6 months</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) <u>181X</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 _____ a.m. _____ p.m. Month, Day, Year _____							
20d. INJURY OCCURRED WHILE AT <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>1950</u> to <u>1957</u> and last saw her alive on <u>Aug 29 - 1957</u> Death occurred at <u>4:25 P. m.</u> on the date stated above; and to the best of my knowledge, from the causes stated.							
22a. SIGNATURE (Degree or title) <u>J. W. Barber MD</u>			22b. ADDRESS <u>Walnut Grove, Mo</u>		22c. DATE SIGNED <u>Aug 30 - 57</u>		
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City, town, or county) (State)	
<u>Buried Aug 31 - 57</u>		<u>Aug 31 - 57</u>		<u>White Chapel Cemetery</u>		<u>Springfield, Mo.</u>	
24. FUNERAL DIRECTOR <u>Brim - Daniel - Walnut Grove - Mo.</u>			25. DATE RECD. BY LOCAL REG. <u>9-3-57</u>		26. REGISTRAR'S SIGNATURE <u>Edith Williams</u>		

(Licensed Embalmer's Statement on Reverse Side)

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

All diseases in Part I must be causally related.

MAR 1 9 1959

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 *Ray L. Samuel*
470

Licensed Embalmer No.
P. O. Address *Ch. Grov*

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.