

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

28750

STATE FILE NUMBER

FILED SEP 10 1957

Registration District No. 207 Primary Registration District No. 4319 Registrar's No. 25

1. PLACE OF DEATH a. COUNTY <u>Maries</u>		2. USUAL RESIDENCE Where deceased lived. If institution: Residence before admission a. STATE <u>Mo</u> b. COUNTY <u>Maries</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Belle</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		c. CITY OR TOWN <u>Belle</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (IF NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>AT home</u> Length of stay in lb <u>6 yrs</u>		d. STREET ADDRESS (If outside, give location) <u>6630</u> Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>	

3. NAME OF DECEASED (Type or print) <u>Amanda Dell Johnson</u> First <u>Amanda</u> Middle <u>Dell</u> Last <u>Johnson</u>			4. DATE OF DEATH <u>Aug 30 - 57</u> Month <u>Aug</u> Day <u>30</u> Year <u>57</u>		
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</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>March 24 - 1882</u>	9. AGE (In years last birthday) <u>75</u>	IF UNDER 1 YEAR: Months <u>7</u> Days <u>5</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, even if retired) <u>Housekeeper</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own home</u>		11. BIRTHPLACE (City and state or country) <u>Missouri</u>	
13. FATHER'S NAME <u>James McQueen</u>			12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		
14. MOTHER'S MAIDEN NAME <u>Rogers</u>			17. INFORMANT <u>Mo Lucy Nummal</u> Address		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>none</u>		17. INFORMANT 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>Coronary Thrombosis</u>		INTERVAL BETWEEN ONSET AND DEATH <u>44 hrs</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>4201</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 8/28/57 to 8/30/57 and last saw her her alive on 8/30/57
Death occurred at 8:15 P.M. on the date stated above; and to the best of my knowledge, from the causes stated.

22a. SIGNATURE R. Holcomb, D.D. (Degree or title) 22b. ADDRESS Belle, Mo 22c. DATE SIGNED 9/3/57

23a. BURIAL, CREMATION, OR OTHER DISPOSAL (Specify) <u>Burial</u>	23b. DATE <u>Sept 2 - 57</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Pilot Knob</u>	23d. LOCATION (City, town or county) (State) <u>Osage County - Mo</u>
24. FUNERAL DIRECTOR'S NAME AND ADDRESS <u>Chas. S. Searles, Belle, Mo</u>		25. DATE RECD. BY LOCAL REG. <u>9-6-57</u>	26. REGISTRAR'S SIGNATURE <u>Pauline Howell</u>

(Licensed Embalmer's Statement on Reverse Side)

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

0630

000
56

NOV 8 1957

NOV 7 1957

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was e
by me, or by Student Embalmer No.....
working under my personal supervision..

Student.....
Signature of Student Embalmer

Signed *Cherita Sarsma*

Licensed Embalmer No. 41

P. O. Address *Blaine*

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.