

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

30373

FILED SEP 9 1957

STATE FILE NUMBER

Registration District No. 317 Primary Registration District No. 548 Registrar's No. 2086

1. PLACE OF DEATH a. COUNTY <u>St. Louis Co.</u>			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>St. Francois</u>		
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Webster Groves, Mo.</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <u>Farmington, Mo.</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>132 W. E. I. M.</u>		Length of stay in 1b <u>2 YEARS</u>	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>Margaret</u> Middle <u>Ann</u> Last <u>Byington</u>			4. DATE OF DEATH Month <u>Aug.</u> Day <u>18</u> Year <u>1957</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>Feb. 20, 1859</u>	9. AGE (In years last birthday) <u>98</u>	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) <u>Retired School Teacher</u>		10b. KIND OF BUSINESS OR INDUSTRY _____	11. BIRTHPLACE (City and state or country) <u>Near Farmington, Mo.</u>	12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Thomas Harvey Haile</u>			14. MOTHER'S MAIDEN NAME <u>Elizabeth Ann Campbell</u>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) _____		16. SOCIAL SECURITY NO. <u>UNKNOWN</u>	17. INFORMANT <u>Mrs. C. J. Davis Webster Groves, 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>Broncho Pneumonia</u>					INTERVAL BETWEEN ONSET AND DEATH <u>3 da</u>
DUE TO (b) <u>Arterio-sclerotic-vascular</u>					DUE TO (c) <u>disease</u>
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"/>
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 _____	Month _____	Day _____	Year _____	
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>Aug 18 1955</u> to <u>Aug 18 1957</u> and last saw her <u>him</u> alive on <u>Aug 18 1957</u> . Death occurred at <u>6:30 A</u> m on the date stated above; and to the best of my knowledge, from the causes stated.					
22a. SIGNATURE (Degree or title) <u>Ed Sheabaugh M.D.</u>			22b. ADDRESS <u>Webster Groves Mo</u>		22c. DATE SIGNED <u>8/19/57</u>
23a. REMOVAL <u>Removal</u>	23b. DATE <u>Aug. 20-57</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Masonic</u>	23d. LOCATION (City, town, or county) <u>Farmington, Mo.</u>	(State) _____	
24. FUNERAL DIRECTOR <u>C. H. Cozean</u>		ADDRESS <u>Farmington, Mo.</u>	25. DATE RECD. BY LOCAL REG. <u>8-21-57</u>	26. REGISTRAR'S SIGNATURE <u>Herbert B. Donald</u>	

(Licensed Embalmer's Statement on Reverse Side)

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE. Coroner cannot certify to a death due to natural causes. Diseases in Part I must be causally related.

MEDICAL CERTIFICATION

**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.....  
*A. Cozart*

Licensed Embalmer No.....

P. O. Address.....  
*Form*

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.