

Health, Welfare & Public Service

300
1-56

doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed. All 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

FILED SEP 20 1957

STANDARD CERTIFICATE OF DEATH

32599

STATE FILE NUMBER

Registration District No. 182 Primary Registration District No. 5686 Registrar's No. 29

1. PLACE OF DEATH a. COUNTY <u>Linn</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Linn</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) <u>Locust Creek Township</u>	Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <u>Brookfield</u>	Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) <u>Locust Creek Turn</u>		d. STREET ADDRESS (If outside, give location) <u>R. F. D. # 3</u>	
Length of stay in 1b <u>17 years</u>		Reside on Farm Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	

3. NAME OF DECEASED (Type or print) <u>Delkia Biery Ireland</u>	4. DATE OF DEATH <u>September 9, 1957</u>
First <u>Delkia</u> Middle <u>Biery</u> Last <u>Ireland</u>	Month <u>September</u> Day <u>9</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"/>	8. DATE OF BIRTH <u>October 28, 1894</u>	9. AGE (In years, last birthday) <u>62</u>	IF UNDER 1 YEAR Month <u>10</u> Day <u>11</u>	IF UNDER 24 HRS. Hours <u>11</u> Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Homemaker</u>		11. BIRTHPLACE (City and state or country) <u>La Mar Colorado U.S.A.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>

13. FATHER'S NAME <u>Robert Henderson</u>	14. MOTHER'S MAIDEN NAME <u>Arvilla Andrews</u>
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO. <u>499-36-5559</u>	17. INFORMANT <u>Li B. Ireland, Brookfield, Mo.</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>cerebro-vascular accident</u>	INTERVAL BETWEEN ONSET AND DEATH <u>12 hours</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>331X</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. _____	
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>Sept 8, 1957</u> to <u>Sept 9, 1957</u> and last saw her alive on <u>Sept 8, 1957</u>	
Death occurred at <u>10:30 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>K. R. Knopf MD</u>	22b. ADDRESS <u>Brookfield, Mo</u>
	22c. DATE SIGNED <u>9-12-57</u>

23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE <u>Sept. 12, 1957</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Rose Hill Cemetery</u>	23d. LOCATION (City, town, or county) (State) <u>Brookfield, Missouri</u>
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24. FUNERAL DIRECTOR <u>J. W. Blacklock, Brookfield, Mo.</u>	25. DATE RECD. BY LOCAL REG. <u>Sept 14-1957</u>	26. REGISTRAR'S SIGNATURE <u>Mrs Birdie Kelley</u>
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Licensed Embalmer's Statement on Reverse Side)

656

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 *Gerald J. Ward*.....

Licensed Embalmer No. *41*

P. O. Address *Brown*

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.