

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH33114
STATE FILE NUMBER

FILED OCT 2 1957

Registration District No. 314 Primary Registration District No. 6062 Registrar's No. 57

1. PLACE OF DEATH a. COUNTY ST CLAIR		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MISSOURI b. COUNTY ST CLAIR	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN VISTA		c. CITY OR TOWN VISTA	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION ROYAL TWP		d. STREET ADDRESS 0938 Reside on Farm	
3. NAME OF DECEASED (Type or print) First Middle Last VIOIA - MELOY		4. DATE OF DEATH Month Day Year SEP 12-1957	
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH DEC 28-1867
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSE WIFE		10b. KIND OF BUSINESS OR INDUSTRY	9. AGE (In years last birthday) IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min. 89
11. BIRTHPLACE (City and state or country) POLK County MO		12. CITIZEN OF WHAT COUNTRY? USA	
13a. FATHER'S NAME WILLIAM CLAY		13b. MOTHER'S MAIDEN NAME UNKNOWN	14. NAME OF HUSBAND OR WIFE Deceased
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO. NO	17. INFORMANT Address John MELOY - OSCEOLA MO
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Chronic Myocarditis			INTERVAL BETWEEN ONSET AND DEATH
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)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> 4222
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 a.m. p.m.			
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 4-4-56 to 9-12-57 and last saw her alive on 9-12-57 Death occurred at 7:40 P m on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE Dr. E. D. Brown DO		22b. ADDRESS Collins MO	
22c. DATE SIGNED 9-14-57			
23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE 9-15-57	23c. NAME OF CEMETERY OR CREMATORY OSCEOLA	23d. LOCATION (City, town, or county) (State) OSCEOLA MO
24. FUNERAL DIRECTOR Goodrich 7-Home Osceola MO		25. DATE RECD. BY LOCAL REG. 9-10-57	26. REGISTRAR'S SIGNATURE Paul S. Sewer

(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.

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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 *J.B. [Signature]*

Licensed Embalmer No. *3038*

P. O. Address *Osceola, Wis*

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.