

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

38820

STATE FILE NUMBER

FILED NOV 12 1957

Registration District No. 324 Primary Registration District No. 30720 Registrar's No. 206

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 casually related. Coroner cannot certify to a death due to natural causes.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

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| 1. PLACE OF DEATH a. COUNTY Saline | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Mo. b. COUNTY Saline | | | | |
| b. CITY (If outside corporate limits, give TOWNSHIP only) Marshall | | Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> | | c. CITY OR TOWN Slater 0971 | | Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> | | |
| c. FULL NAME OF (If NOT in hospital, give location) Fitzgibbons | | | Length of stay in lb 2 wks | d. STREET ADDRESS Front St. | | | Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) Margie | | | | First Margie | Middle | Last Wood | 4. DATE OF DEATH Nov. 7-1957 | |
| 5. SEX Female 3 | 6. COLOR OR RACE negro | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH April, 1879 | | 9. AGE (In years last birthday) 79 plus | IF UNDER 1 YEAR Months Days Hours Min. | IF UNDER 24 HRS. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) at home | | | 10b. KIND OF BUSINESS OR INDUSTRY none | | 11. BIRTHPLACE (City and state or country) Saline Co. Mo. 0 | | 12. CITIZEN OF WHAT COUNTRY? US | |
| 13. FATHER'S NAME Nimrod Pryor | | | | 14. MOTHER'S MAIDEN NAME Maiah | | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give year or dates of service) no | | 16. SOCIAL SECURITY NO. no | | 17. INFORMANT Veta Graves | | Address Slater, 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 nephritis & uremia DUE TO (b) Chronic myocarditis Essential hypertension DUE TO (c) Broncho pneumonia - Bilateral PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | | | | | INTERVAL BETWEEN ONSET AND DEATH 3 days - 6 days 2 yr. 3 yr. 8 days | |
| 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 9:30 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 June 1940 to Nov. 7, 1957 and last saw her alive on 11-7-57 Death occurred at 9:30 A m on the date stated above; and to the best of my knowledge, from the causes stated. | | | | | | | | |
| 22a. SIGNATURE C. C. McBurney, MD | | | | 22b. ADDRESS Slater, Mo. | | 22c. DATE SIGNED 11/8/57 | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 23b. DATE 11/9/1957 | 23c. NAME OF CEMETERY OR CREMATORY City Cemetery | | 23d. LOCATION (City, town, or county) Slater, Mo. | | | |
| 24. FUNERAL DIRECTOR Hill Brothers | | | | ADDRESS Slater | | 25. DATE RECD. BY LOCAL REG. 11-8-57 | 26. REGISTRAR'S SIGNATURE Cecil J. Neal | |

(Licensed Embalmer's Statement on Reverse Side)

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. C. Hill*

Licensed Embalmer No. *309*

P. O. Address *State*

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (F 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.