

FILED NOV 6 1957

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

STATE FILE NUMBER

Registration District No. 378 Primary Registration District No. 4552 Registrar's No. 52

1. PLACE OF DEATH a. COUNTY <u>Wright</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Texas</u>				
b. CITY (If outside corporate limits, give TOWNSHIP only) <u>Mt. Grove</u>			Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <u>Cabool</u>		1070 0		
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>Avalon Rest Home</u>			Length of stay in lb		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>RENNIE</u> Middle <u>SHERMAN</u> Last <u>BACKUS</u>				4. DATE OF DEATH Month <u>Oct.</u> Day <u>5</u> Year <u>1957</u>				
5. SEX <u>Male</u> <u>0</u>		6. COLOR OR RACE <u>white</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> <u>WIDOWED</u> <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>July 4, 1867</u>		
9. AGE (In years last birthday) <u>90</u>		IF UNDER 1 YEAR Months <u>3</u> Days <u>1</u> Hours <u></u> Min <u></u>		IF UNDER 24 HRS. Hours <u></u> Min <u></u>				
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farming</u>				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (City and state or country) <u>Ottawa, Illinois</u>		
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>								
13. FATHER'S NAME <u>Jerome Backus</u>				14. MOTHER'S MAIDEN NAME <u>Susan Eaton</u>				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>no</u>				16. SOCIAL SECURITY NO. <u>none</u>		17. INFORMANT <u>Rosemary Lee, Mt. Grove, 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>Coronary Arteriosclerosis</u> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <u>Arteriosclerosis, Hypertension</u> DUE TO (c) <u></u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>4201</u>								
INTERVAL BETWEEN ONSET AND DEATH <u>Not known</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 <u></u> Month <u></u> Day <u></u> Year <u></u> a. m. <u></u> p. m. <u></u>								
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>6-10-57</u> to <u>10-5-57</u> and last saw <u>her</u> alive on <u>9-20-57</u> Death occurred at <u>4:40 Pm</u> on the date stated above; and to the best of my knowledge, from the causes stated.								
22a. SIGNATURE (Degree or title) <u>Ed Connor M.D.</u>				22b. ADDRESS <u>Mountain Grove Mo</u>		22c. DATE SIGNED <u>10/17/57</u>		
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>burial</u>		23b. DATE <u>Oct. 8-57</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Penner Cemetery</u>		23d. LOCATION (City, town, or county) <u>Douglas County, Mo.</u>		
24. FUNERAL DIRECTOR <u>ELLIOTT-GENTRY</u>		ADDRESS <u>CABOOL, MO.</u>		25. DATE RECD. BY LOCAL REG. <u>10-22-57</u>		26. REGISTRAR'S SIGNATURE <u>A. B. Ames</u>		

(Licensed Embalmer's Statement on Reverse Side)

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

RECEIVED 10-28-57  
WRIGHT CO. HEALTH DEPT  
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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 *James L. Gentry*

Licensed Embalmer No. 4716

P. O. Address *Calrol*

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.