

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 DEC 12 1957

STANDARD CERTIFICATE OF DEATH

STATE FILE NUMBER 55888

Registration District No. 43 Primary Registration District No. 3007 Registrar's No. 36

1. PLACE OF DEATH a. COUNTY <b>BUTLER</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MISSOURI</b> b. COUNTY <b>DUNKLIN</b>				
b. CITY (If outside corporate limits, give TOWNSHIP only) TOWN <b>POPLAR BLUFF</b>			Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <b>GLENNONVILLE, MO.</b>			Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>DOCTORS HOSP.</b>			Length of stay in 1b <b>5 days</b>	d. STREET ADDRESS (If outside, give location) <b>GLENNONVILLE, MO.</b>			Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>MARGARET</b> Middle <b>HENRETTA</b> Last <b>HUSTEDDE</b>				4. DATE OF DEATH Month <b>NOV</b> Day <b>17</b> Year <b>1957</b>				
5. SEX <b>FEMALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>AUG. 26, 1893</b>		9. AGE (In years last birthday) <b>64</b>		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>H OUSEWIFE</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>HOME</b>		11. BIRTHPLACE (City and state or country) <b>ST. JOHNS, IND.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		
13. FATHER'S NAME <b>ALOYS EBERHARD</b>				14. MOTHER'S MAIDEN NAME <b>ANTONETTE TELLER</b>				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yrs, give war or dates of service) <b>NO</b>		16. SOCIAL SECURITY NO. <b>NONE</b>		17. INFORMANT Address <b>JOSEPH HUSTEDDE GLENNONVILLE, MO</b>				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Myocardial Infarct</b> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. } DUE TO (b) <b>Coronary Atherosclerosis</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) <b>4201</b>							INTERVAL BETWEEN ONSET AND DEATH <b>Months</b> <b>2 weeks</b>	
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. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)				20e. CITY, TOWN, OR LOCATION <b>GLENNONVILLE</b>	20f. COUNTY <b>MO.</b>
20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			20e. CITY, TOWN, OR LOCATION <b>GLENNONVILLE</b>					20f. COUNTY <b>MO.</b>
21. I attended the deceased from <b>11-13-57</b> to <b>11-17-57</b> and last saw her <sup>her</sup> <sub>him</sub> alive on <b>11-16-57</b> . Death occurred at <b>6:45 P.M.</b> m on the date stated above, and to the best of my knowledge, from the causes stated.								
22a. SIGNATURE <i>[Signature]</i> (Degree or title)				22b. ADDRESS <b>Poplar Bluff, Mo</b>		22c. DATE SIGNED <b>12-2-57</b>		
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		23b. DATE <b>11-20-57</b>	23c. NAME OF CEMETERY OR CREMATORY <b>ST. TERESA</b>		23d. LOCATION (City, town, or county) (State) <b>GLENNONVILLE, MO.</b>			
24. FUNERAL DIRECTOR ADDRESS <b>DAY FUNERAL HOME MALDEN, MO</b>			25. DATE RECD. BY LOCAL REG. <b>17/4/57</b>		26. REGISTRAR'S SIGNATURE <i>[Signature]</i>			

489-0

RECEIVED

DEC 9 1957

BUTLER CO. HEALTH CENTER

FILE No. \_\_\_\_\_

---

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. L. Schuman* \_\_\_\_\_

Licensed Embalmer No. 408

P. O. Address Malden

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.