

FILED DEC 2 - 1957

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

41232

STATE FILE NUMBER

Registration District No. 241 Primary Registration District No. 5829 Registrar's No. 24

1. PLACE OF DEATH a. COUNTY <b>New Madrid</b>			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Missouri</b> b. COUNTY <b>New Madrid</b>		
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>Rural Gideon Portage Mo.</b>		Inside Limits No <input checked="" type="checkbox"/> Yes <input type="checkbox"/>	c. CITY OR TOWN <b>Gideon</b>		Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>Rural Route 1</b>		Length of stay in lb <b>5 Yrs.</b>	STREET ADDRESS (If outside, give location) <b>Rural Route 1</b>		Reside on Farm Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <b>Eda</b> Middle <b>Mary Louvina</b> Last <b>Tutner</b>			4. DATE OF DEATH Month <b>Nov.</b> Day <b>16,</b> Year <b>1957</b>		
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>3-1-1879</b>	9. AGE (In years last birthday) <b>78</b>	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>House-wife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>x</b>	11. BIRTHPLACE (City and state or country) <b>Vienna, Arkansas</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>
13a. FATHER'S NAME <b>John Taylor</b>		13b. MOTHER'S MAIDEN NAME <b>Unknown</b>		14. NAME OF HUSBAND OR WIFE <b>Deceased</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No x</b>		16. SOCIAL SECURITY NO. <b>x</b>	17. INFORMANT Address <b>George Sims Wardell, 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>Cerebrovascular accident</b>				INTERVAL BETWEEN ONSET AND DEATH <b>30 min</b>	
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. } DUE TO (b) <b>Arteriosclerosis</b>				10 years	
DUE TO (c) <b>331X</b>					
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"/>
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 <b>Jan 1954</b> to <b>Nov 16 1957</b> and last saw her alive on <b>Nov 16 1957</b> Death occurred at <b>9:00 P.M.</b> m on the date stated above; and to the best of my knowledge, from the causes stated.					
22a. SIGNATURE (Degree or title) <b>Daniel R Henley MD</b>			22b. ADDRESS <b>PO Box 296 Wardell</b>		22c. DATE SIGNED <b>11/18/57</b>
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE <b>11-19-57</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Wardell Memorial</b>		23d. LOCATION (City, town, or county) (State) <b>Wardell, Mo.</b>
24. FUNERAL DIRECTOR <b>Osburn Funeral Home, Wardell, Mo.</b>			25. DATE RECD. BY LOCAL REG. <b>11/22/57</b>	26. REGISTRAR'S SIGNATURE <b>Ellen H. G. [Signature]</b>	

(Licensed Embalmer's Statement on Reverse Side)

Health, Welfare, Public Service

300  
-57

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.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

119  
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DATE RECEIVED NOV 27 1957  
NEW MADRID CO. HEALTH CENTER

*J. A. Saborn*

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 A. Saborn*

Licensed Embalmer No. 4185  
P. O. Address Wardell, Mo.

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.