

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.

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

43294

STATE LICENSE NUMBER

FILED DEC 10 1957

Registration District No. 360 Primary Registration District No. 6225 Registrar's No. 196

1. PLACE OF DEATH a. COUNTY <u>Vernon</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Cedar</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Washington Township</u>		c. CITY OR TOWN <u>Captlinger Mills</u>	
c. FULL NAME OF (NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>State Hospital #3</u>		d. STREET ADDRESS (If outside, give location)	
Length of stay in lb <u>3 m. 10 d.</u>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	

3. NAME OF DECEASED (Type or print) First <u>Myrtle</u> Middle <u>E.</u> Last <u>Dawes</u>			4. DATE OF DEATH Month <u>12</u> Day <u>3</u> Year <u>1957</u>			
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5. SEX <u>Female</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>December 24, 1880</u>	9. AGE (In years last birthday) <u>76</u>	10. UNDER 1 YEAR Months <u>11</u> Days <u>9</u>	11. IF UNDER 24 HRS. Hours <u>—</u> Min. <u>—</u>
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10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>housewife</u>	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and state or country) <u>Captlinger Mills MO</u>	12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>
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13a. FATHER'S NAME <u>Thomas Kennedy</u>	13b. MOTHER'S MAIDEN NAME <u>Lydia J. Hornbeck</u>	14. NAME OF HUSBAND OR WIFE <u>deceased</u>
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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>Hospital Records, State Hospital #3, Nevada, Mo</u>
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18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. CAUSE WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Arteriosclerotic Heart Disease</u>		INTERVAL BETWEEN ONSET AND DEATH <u>4 years</u>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b)	
	DUE TO (c) <u>4200</u>	

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>Chronic Brain Syndrome, Cir. Circulatory disturbance, Central Art. scl. & Psychosis</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
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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.) <u>—</u>
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20c. TIME OF INJURY Hour <u>—</u> Month, Day, Year a.m. <u>—</u> p.m. <u>—</u>	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.) <u>—</u>	20f. CITY, TOWN, OR LOCATION <u>—</u>	COUNTY <u>—</u> STATE <u>—</u>
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21. I attended the deceased from <u>August 23, 1957</u> to <u>Dec. 3, 1957</u> and last saw her alive on <u>December 2nd, 1957</u> Death occurred at <u>4:20 P.M.</u> on the date stated above; and to the best of my knowledge, from the causes stated.

22a. SIGNATURE <u>George Esker M.D.</u> (Degree or title)	22b. ADDRESS <u>State Hospital #3, Nevada, Mo.</u>	22c. DATE SIGNED <u>12.3.57</u>
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23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE <u>12-3-57</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Captlinger Cem.</u>	23d. LOCATION (City, town, or county) (State) <u>Cedar Co. Mo.</u>
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24. FUNERAL DIRECTOR <u>Charles James Hue</u>	ADDRESS <u>Stockton, Mo.</u>	25. DATE RECD. BY LOCAL REG. <u>12-4-1957</u>	26. REGISTRAR'S SIGNATURE <u>Arma E. Perry</u>
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USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

DEC 11 1957

DEC 18 1957

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 *[Signature]*

Licensed Embalmer No. 4853
P. O. Address Florida, 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.