

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 23 1957

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

437330

STATE FILE NUMBER

Registration District No. 53 Primary Registration District No. 4078 Registrar's No. 80

1. PLACE OF DEATH a. COUNTY <u>Cape Girardeau</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Cape</u>			
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Delta Mo.</u>			Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <u>Delta</u>		016 ⁰ 0	Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>Family Home</u>			Length of stay in lb <u>80 yr</u>		d. STREET ADDRESS <u>None</u> (If outside, give location)		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <u>Ida</u> Middle <u>Belle</u> Last <u>Hubbard</u>				4. DATE OF DEATH Month <u>Dec</u> Day <u>13</u> Year <u>1957</u>			
5. SEX <u>Female</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>Dec 3 1867</u>		9. AGE (In years last birthday) <u>90</u>	IF UNDER 1 YEAR Months <u>10</u> Days <u>10</u> Hours <u>10</u> Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>		11. BIRTHPLACE (City and state or country) <u>Knox County Ky</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>
13. FATHER'S NAME <u>Jacob Shuls</u>				14. MOTHER'S MAIDEN NAME <u>Elizabeth Jan (Last Name Unknown)</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>no</u>		17. INFORMANT Address <u>Mrs. Wm Ratledge Delta 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>Cerebral hemorrhage</u> DUE TO (b) <u>hypertension</u> DUE TO (c) <u>old age</u> 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 <u>5 days</u>
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 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>Aug 9 57</u> to <u>Dec 13 57</u> and last saw <u>him</u> <u>alive on Dec 9 57</u> Death occurred at _____ on the date stated above; and to the best of my knowledge, from the causes stated.							
22a. SIGNATURE <u>Wm Ratledge M.D.</u> (Degree in title)				22b. ADDRESS <u>Delta Mo.</u>		22c. DATE SIGNED <u>Dec 13 57</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE	23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City, town, or county)		(State)
<u>Burial</u>		<u>12-15-1957</u>	<u>Zion Cemetery</u>		<u>Gordonville Mo.</u>		
24. FUNERAL DIRECTOR <u>Brinkopf Howell Funeral Home</u> ADDRESS <u>W. Estus</u>			25. DATE RECD. BY LOCAL REG. <u>12-19-57</u>		26. REGISTRAR'S SIGNATURE <u>Melford Wincheste Dep</u>		

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 *Neil H. Grossbeider*

Licensed Embalmer No. 4899

P. O. Address *Cape Girardeau*

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.