

Securing the medical certification in this specific manner required by 193.10 MoRS 1949.
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 JAN 6 1958

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

438883

STATE FILE NUMBER

Registration District No. 82 Primary Registration District No. 3017 Registrar's No. 163

1. PLACE OF DEATH a. COUNTY <u>COOPER</u>			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MISSOURI</u> b. COUNTY <u>COOPER</u>		
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>BOONVILLE MO</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <u>PRAIRIE HOME</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>ST. JOSEPH</u>		Length of stay in lb <u>2 Hours</u>		d. STREET ADDRESS (If outside, give location) <u>PRAIRIE HOME MO</u>	
3. NAME OF DECEASED (Type or print) First <u>MAY</u> Middle <u>ELIZABETH</u> Last <u>WHALEN</u>			4. DATE OF DEATH <u>DEC. 28-1957</u> Month Day Year		
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>JULY 30-1887</u>	9. AGE (In years last birthday) <u>70</u>	IF UNDER 1 YEAR Months <u>4</u> Days <u>28</u> Hours <u></u> Min. <u></u>
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>OWN HOME</u>		11. BIRTHPLACE (City and state or country) <u>MISSOURI</u>	
13. FATHER'S NAME <u>ELISHA SCOTT</u>			14. MOTHER'S MAIDEN NAME <u>SARAH McLAUGHLIN</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>499-40488</u>		17. INFORMANT <u>D. Whalen Prairie Home Mo</u> Address	
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>Acute Myocardial Infarction</u> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. } DUE TO (b) <u>Arteriosclerotic Heart Disease</u> DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>4200</u>					INTERVAL BETWEEN ONSET AND DEATH <u>± 2 hours</u> <u>± 2 months</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>12-4-57</u> , to <u>12-28-57</u> and last saw her ^{her} _{him} alive on <u>12-28-57</u> Death occurred at <u>1:30 PM</u> m on the date stated above; and to the best of my knowledge, from the causes stated.					
22a. SIGNATURE (Degree or title) <u>B. M. Stuart M.D.</u>			22b. ADDRESS <u>329 Main, Boonville, Mo</u>		22c. DATE SIGNED <u>12-30-57</u>
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE <u>DEC. 31-1957</u>	23c. NAME OF CEMETERY OR CREMATORY <u>WALNUT GROVE</u>		23d. LOCATION (City, town, or county) (State) <u>BOONVILLE MO</u>
24. FUNERAL DIRECTOR <u>CALBERT HOTNISEK</u> <u>PRAIRIE HOME MO.</u>		25. DATE RECD. BY LOCAL REG. <u>12/29-57</u>		26. REGISTRAR'S SIGNATURE <u>D. Cooper</u>	

JAN 13 1958

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 *C. Albert Hornbeck*

Licensed Embalmer No. *271*

P. O. Address *Bairie Ho*

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.