

FILED DEC 24 1957

STANDARD CERTIFICATE OF DEATH

46996

STATE FILE NUMBER

Registration District No. 337 Primary Registration District No. 4497 Registrar's No. 101

1. PLACE OF DEATH a. COUNTY <b>SHELBY</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MO</b> b. COUNTY <b>SHELBY</b>			
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>CLARENCE</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		c. CITY OR TOWN <b>CLARENCE</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>CLARENCE MO</b>			Length of stay in 1b <b>3 yrs</b>			d. STREET ADDRESS (If outside, give location) <b>CLARENCE MO</b>	
3. NAME OF DECEASED (Type or print) First <b>LUELLA</b> Middle <b>JANE</b> Last <b>DESPAIN</b>				4. DATE OF DEATH Month <b>DEC</b> Day <b>9</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>JUNE 17 1873</b>		9. AGE (In years last birthday) <b>84</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>HOUSEWIFE</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>HOUSEWIFE</b>		11. BIRTHPLACE (City and state or country) <b>IOWA</b>		12. CITIZEN OF WHAT COUNTRY? <b>US</b>	
13. FATHER'S NAME <b>GEORGIE HALE</b>				14. MOTHER'S MAIDEN NAME <b>DELANAH MC CUNE</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>NO</b>		16. SOCIAL SECURITY NO. <b>NONE</b>		17. INFORMANT <b>MRS RAYEL LONG</b>		Address <b>ANABEL 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>Acute myocardial Failure</b>							INTERVAL BETWEEN ONSET AND DEATH <b>5 minutes</b>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.							DUE TO (b) <b>chronic myocardial weakness</b>
DUE TO (c)							1 months
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"/> <b>2</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 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 <b>Nov. 6, 1957</b> to <b>Dec. 9, 1957</b> and last saw her alive on <b>Dec. 9, 1957</b> Death occurred at <b>6 p m</b> on the date stated above; and to the best of my knowledge, from the causes stated.							
22a. SIGNATURE (Degree or title) <b>B. L. Edgington D.D.</b>				22b. ADDRESS <b>Clarence, Mo.</b>		22c. DATE SIGNED <b>12-17-57</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		23b. DATE <b>12-19-57</b>	23c. NAME OF CEMETERY OR CREMATORY <b>BETHLEHEM CEMETERY</b>		23d. LOCATION (City, town, or county) (State) <b>MACON COUNTY MO</b>		
24. FUNERAL DIRECTOR <b>Chas. V. Sheering</b>			ADDRESS <b>Clarence Mo</b>		25. DATE RECD. BY LOCAL REG. <b>12-18-57</b>		26. REGISTRAR'S SIGNATURE <b>Cda Garrison</b>

(Licensed Embalmer's Statement on Reverse Side)

300  
1-56

All diseases in Part I must be casually related. Coroner cannot certify to a death due to natural causes. Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed. All

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE.

MEDICAL CERTIFICATION

19 - 0

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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 *Paul V. Green* .....

Licensed Embalmer No. *462*

P. O. Address *Cheneca*

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.