

FILED DEC 17 1957

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

47068

STATE FILE NUMBER

Registration District No. 360 Primary Registration District No. 3076 Registrar's No. 229

1. PLACE OF DEATH a. COUNTY <b>Wyo</b> <b>Vernon</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Missouri</b> b. COUNTY <b>Vernon</b>			
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>Nevada</b>				Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		c. CITY OR TOWN <b>Nevada</b>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>#411 So. Ash St. Fanning Nursing Home</b>				Length of stay in lb <b>9mo.</b>		d. STREET ADDRESS (If outside, give location) <b>209 N. Ash</b>	
3. NAME OF DECEASED (Type or print) First <b>Avo</b> Middle <b>Alice</b> Last <b>Lile</b>				4. DATE OF DEATH Month <b>Nov</b> Day <b>28</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"/> <b>WIDOWED</b> <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>Sept. 30, 1868</b>	
				9. AGE (In years last birthday) <b>89</b>		IF UNDER 1 YEAR Months <b>0</b> Days <b>0</b>	
						IF UNDER 24 HRS. Hours <b>0</b> Min. <b>0</b>	
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>At Home</b>		11. BIRTHPLACE (City and state or country) <b>Tenn.</b>	
13. FATHER'S NAME <b>Thomas M. Rabon</b>				14. MOTHER'S MAIDEN NAME <b>Catherine Sidney</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <b>none</b>		17. INFORMANT Address <b>Mrs. Effie Hudson Kansas City, 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>Arteriosclerotic Heart Disease, Class IV with pleural effusion, right.</b>							INTERVAL BETWEEN ONSET AND DEATH <b>known</b> <b>Jan 1957</b>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.							DUE TO (b) _____ DUE TO (c) _____
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.) <b>4200</b>				
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 <b>4200</b>			
			COUNTY _____		STATE _____		
21. I attended the deceased from <b>1/14/57</b> to <b>11/28/57</b> and last saw her alive on <b>11/20/57</b> Death occurred at <b>10:55</b> <b>A</b> m on the date stated above; and to the best of my knowledge, from the causes stated.							
22a. SIGNATURE (Name or title) <b>James J. Jacob MD</b>				22b. ADDRESS <b>Moore Bldg., Nevada, Mo</b>		22c. DATE SIGNED <b>12/2/57</b>	
23a. BURIAL, CREMATION, REBURYAL (Specify) <b>Burial</b>		23b. DATE <b>11-30-57</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Newton Burial Park</b>		23d. LOCATION (City, town, or county) (State) <b>Nevada, Mo.</b>	
24. FUNERAL DIRECTOR ADDRESS <b>Eichinger Funeral Home, Nevada, Mo</b>				25. DATE RECD. BY LOCAL REG. <b>12-9-1957</b>		26. REGISTRAR'S SIGNATURE <b>Arma E. Ferry</b>	

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

Health, & Welfare  
S. Public Health Service

S. 300  
v. 1-56

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

Securely the medical certification in the specific manner required by 193.140 MOKS 1949.

4 31 6

(Licensed Embalmer's Statement on Reverse Side)

**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. ~~797~~ working under my personal supervision.

Student .....  
Signature of Student Embalmer

Signed *Francis C. Marsh* .....

Licensed Embalmer No. *49*

P. O. Address *Nevada*

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.