

000-56
 diseases in Part I must be causally related. Caroner cannot certify to a death due to natural causes.
 USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

THE DIVISION OF HEALTH OF MISSOURI
 STANDARD CERTIFICATE OF DEATH

192

FILED JAN 20 1958

STATE FILE NUMBER

Registration District No. 38 Primary Registration District No. 3006 Registrar's No. 21

1. PLACE OF DEATH a. COUNTY <u>Boone</u>			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Boone</u>		
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Columbia</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <u>Columbia</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>112 N. Garth Ave.</u>		Length of stay in 1b <u>12 Yrs</u>	d. STREET ADDRESS <u>112 N. Garth Ave.</u>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <u>Judie</u> Middle <u>Bell</u> Last <u>Layman</u>			4. DATE OF DEATH Month <u>1</u> Day <u>13</u> Year <u>1958</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>4-15-1878</u>	9. AGE (In years last birthday) <u>79</u>	IF UNDER 1 YEAR Months _____ Days _____
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>Home</u>	11. BIRTHPLACE (City and state or country) <u>Iberia, Missouri</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>
13. FATHER'S NAME <u>W. T. Marten</u>			14. MOTHER'S MAIDEN NAME <u>Fletcher</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>---</u>	17. INFORMANT Address <u>Mrs. W.A. Dickerson, Columbia, 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 Venous Thrombosis</u>					INTERVAL BETWEEN ONSET AND DEATH <u>24 hrs</u>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.					DUE TO (b) <u>Arterio Sclerosis</u> <u>10 yrs</u>
					DUE TO (c) <u>Pulmonary Tuberculosis</u> <u>?</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>002X</u>					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> <u>2</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.) <u>✓</u>		
20c. TIME OF INJURY Hour _____ Month _____ Day _____ a. m. _____ p. m. _____		20d. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) <u>✓</u>			
20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		20e. CITY, TOWN, OR LOCATION <u>---</u>		COUNTY	STATE
21. I attended the deceased from <u>Jan - 1946</u> to <u>Jan - 10 - 58</u> and last saw her alive on <u>1-17-58</u> Death occurred at <u>12 P. M.</u> m on the date stated above; and to the best of my knowledge, from the causes stated.					
22a. SIGNATURE <u>F. C. Dugard M.D.</u> (Degree or title)			22b. ADDRESS <u>Columbia, Mo</u>		22c. DATE SIGNED <u>1-16-58</u>
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE <u>1-16-1958</u>	23c. NAME OF CEMETERY OR CREMATORY <u>IOOF Cemetery</u>		23d. LOCATION (City, town, or county) (State) <u>Marionville, Mo.</u>	
24. FUNERAL DIRECTOR <u>Lyman Sprinkle, Columbia, Mo.</u>			25. DATE RECD. BY LOCAL REG. <u>Jan 15, 1958</u>	26. REGISTRAR'S SIGNATURE <u>Mrs. R. E. Palmer</u>	

APR 11 1958

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was e
by me, ~~or by~~, Student Embalmer No.....
working under my personal supervision..

Student.....
Signature of Student Embalmer

Signed *Lyman J. Sprinkle*

Licensed Embalmer No. 401

P. O. Address *Columba*

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING.
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.