Health, Welfare & Public Service

0470

300
1-56

FILED FEB 11 1958

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

1125
STATE FILE NUMBER

Registration District No. 144 Primary Registration District No. 5562 Registrar's No. 9

1. PLACE OF DEATH
a. COUNTY Iron
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Rural-Arcadia — Inside Limits Yes ☐ No ☒
c. FULL NAME OF HOSPITAL OR INSTITUTION (If NOT in hospital, give location) The Home for Aged Baptists — Length of stay in 1b 3yr.10mo.6da.

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Mo. b. COUNTY Iron
c. CITY OR TOWN Rural-Arcadia 0470 — Inside Limits Yes ☐ No ☒
d. STREET ADDRESS (If outside, give location) 1½ Mi. E. on Hwy. 70 — Reside on Farm Yes ☐ No ☒

3. NAME OF DECEASED (Type or print) First Marie Middle Eliza Last Albang
4. DATE OF DEATH Month Feb. Day 3. Year 1958
5. SEX Female
6. COLOR OR RACE White
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH May 22.1877
9. AGE (In years last birthday) 80 — IF UNDER 1 YEAR Months 8 Days 12 — IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife
10b. KIND OF BUSINESS OR INDUSTRY own home
11. BIRTHPLACE (City and state or country) Cyrene, Missouri
12. CITIZEN OF WHAT COUNTRY? U.S.
13. FATHER'S NAME Jacob E. Bailey
14. MOTHER'S MAIDEN NAME Eliza Grafford
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no (If yes, give war or dates of service)
16. SOCIAL SECURITY NO. none
17. INFORMANT Address Dolores Weiss, Ironton, Mo.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Arteriosclerotic Heart Disease — INTERVAL BETWEEN ONSET AND DEATH 1 year
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) 4200
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒ 2

20a. ACCIDENT ☐ SUICIDE ☐ HOMICIDE ☐
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year
20d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
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 July 1 '57 to Feb 3, '58 and last saw her/him alive on Jan 31, '58
Death occurred at 7:45 A. m on the date stated above; and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) Marvin C. Maune, MD
22b. ADDRESS Ironton, Mo
22c. DATE SIGNED 2-4-58

23a. BURIAL, CREMATION, REMOVAL (Specify) Burial
23b. DATE 2-4-58
23c. NAME OF CEMETERY OR CREMATORY Home Cemetery
23d. LOCATION (City, town, or county) (State) Ironton Mo
24. FUNERAL DIRECTOR White Funeral Home, Ironton — ADDRESS
25. DATE RECD. BY LOCAL REG. 2-5-58
26. REGISTRAR'S SIGNATURE Mrs Avis Jones

Avis White (Licensed Embalmer's Statement on Reverse Side)

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.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was em

by me, or by ....., Student Embalmer No.....

working under my personal supervision..

Student.....
Signature of Student Embalmer

Signed Arnold J. White.....

Licensed Embalmer No 3.01.2

P. O. Address Boston

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.