

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

STATE FILE NUMBER

FILED FEB 4 1958

Registration District No. 360 Primary Registration District No. 3076 Registrar's No. 14

Health,
Welfare
Public
Service

300
1-57

1. PLACE OF DEATH a. COUNTY VERNON		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MISSOURI b. COUNTY VERNON	
b. CITY OR TOWN NEVADA Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		c. CITY OR TOWN MILO, MO. Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION FANNING REST HOME		d. STREET ADDRESS (If outside, give location) 2 YRS Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First ROSE Middle Last HUMPHREY			4. DATE OF DEATH Month JAN Day 23 Year 1958
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH JULY 17, 1874
9. AGE (In years last birthday) 83		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSE WIFE	11. BIRTHPLACE (City and state or country) FOUNTAIN, CO., IND.
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13a. FATHER'S NAME LANDA BEAVER	13b. MOTHER'S MAIDEN NAME REBECCA HIESTAND
14. NAME OF HUSBAND OR WIFE JAMES HUMPHREY		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) NO	16. SOCIAL SECURITY NO. NONE
17. INFORMANT JOE BEAVER		Address NEVADA, MO.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Hemorrhage Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. } DUE TO (b) Hypertension. Cerebral DUE TO (c) Arteriosclerosis.			INTERVAL BETWEEN ONSET AND DEATH 1 day.
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? NO
20a. ACCIDENT SUICIDE HOMICIDE none		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.) none	
20c. TIME OF INJURY none			
20d. INJURY OCCURRED WHILE AT WORK	20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) none	20f. CITY, TOWN, OR LOCATION Nevada	COUNTY Vernon STATE Mo.
21. I attended the deceased from Nov 14/57 to Jan 23/58 and last saw her alive on Jan 22-58 Death occurred at _____ on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE W. E. Love MD		22b. ADDRESS Nevada Mo	22c. DATE SIGNED 1-24-58
23a. BURIAL, CREMATION, REMOVAL (Specify) BORIAL	23b. DATE JAN 26-58	23c. NAME OF CEMETERY OR CREMATORY MILO CEMETERY	23d. LOCATION (City, town, or county) MILO (State) MO
24. FUNERAL DIRECTOR BEENEY FUNERAL HOME		25. DATE RECD. BY LOCAL REG 1-29-58	26. REGISTRAR'S SIGNATURE Anna E. Perry

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE
MEDICAL CERTIFICATION

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.

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 *J. Bernard Perry*

Licensed Embalmer No. *4161*

P. O. Address. *Sheldon Mo*

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.