

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

58-010626

FILE NUMBER

FILED APR 8 1958

Registration District No. 184

Primary Registration District No. 3099

Registrar's No. 43

health, Welfare Public Service
300 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 causally related. Coroner cannot certify to a death due to natural causes.
USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

1. PLACE OF DEATH a. COUNTY <u>LINN</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MISSOURI</u> b. COUNTY <u>LINN</u>			
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>YELLOW CREEK TWP</u>		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>		c. CITY OR TOWN <u>ST. CATHERINE</u>		Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>RFD ST. CATHERINE</u>			Length of stay in 1b	d. STREET ADDRESS <u>RFD #1</u>			Reside on Farm Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <u>MYRTIE</u> Middle <u>ROBERSON</u> Last <u>ROBERSON</u>				4. DATE OF DEATH <u>MAR. 28, 1958</u> Month <u>MAR.</u> Day <u>28</u> Year <u>1958</u>			
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> / DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>FEB. 3, 1887</u>		9. AGE (In years last birthday) <u>71</u>	IF UNDER 1 YEAR Months <u>7</u> Days <u>1</u> Hours <u>0</u> Min. <u>0</u>
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>OWN HOME</u>		11. BIRTHPLACE (City and state or country) <u>ST. CATHERINE, MO</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>
13. FATHER'S NAME <u>LAWRENCE CUTLER</u>				14. MOTHER'S MAIDEN NAME <u>MARY ELIZABETH STERNKE</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>NONE</u>		17. INFORMANT <u>H.E. ROBERSON, ST. CATHERINE, 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>Acute Uremia</u>							INTERVAL BETWEEN ONSET AND DEATH <u>12 months</u>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.			DUE TO (b) <u>Congestive heart failure</u>				<u>8 years</u>
			DUE TO (c) <u>Chronic Myocarditis</u>				<u>14 years</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (n) <u>Coronary Thrombosis 10 years ago.</u>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
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>2</u>				
20c. TIME OF INJURY Hour <u>11:40</u> a. m. <u>A.</u> Month <u>March</u> Day <u>27</u> Year <u>1958</u> 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 <u>Brookfield, Missouri</u>		STATE <u>MO</u>	
21. I attended the deceased from <u>1951</u> to <u>March 27, 1958</u> and last saw her alive on <u>March 27, 1958</u> Death occurred at <u>11:40 A.</u> m on the date stated above, and to the best of my knowledge, from the causes stated.							
22a. SIGNATURE <u>R. L. Rye</u> (Degree or title) <u>D.O. 2</u>				22b. ADDRESS <u>Brookfield, Missouri</u>		22c. DATE SIGNED <u>3-29-58</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE <u>MAR. 30, 1958</u>	23c. NAME OF CEMETERY OR CREMATORY <u>ROSE HILL</u>		23d. LOCATION (City, town, or county) (State) <u>BROOKFIELD, MO</u>		
24. FUNERAL DIRECTOR <u>WRIGHT FUNERAL HOME, BROOKFIELD, MO</u>			25. DATE RECD. BY LOCAL REG. <u>3-31-58</u>		26. REGISTRAR'S SIGNATURE <u>Katharine Johnson</u>		

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..... *Harold B. Wright*

Licensed Embalmer No. *371*

P. O. Address *Beneficial*

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.