

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

58-010790
STATE FILE NUMBER

FILED APR 7 1958

Registration District No. 236

Primary Registration District No. 5819

Registrar's No. 25

| | | | | | | | |
|---|------------------------------------|---|--|---|--|--|---|
| 1. PLACE OF DEATH a. COUNTY <u>Morgan</u> | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Candolph</u> | | | |
| b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Rural Osage</u> | | | Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> | c. CITY OR TOWN <u>Huntsville 0880</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 | | | Length of stay in lb | d. STREET ADDRESS (If outside, give location) <u>105 Library ST</u> | | | Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> |
| 3. NAME OF DECEASED (Type or print) First <u>Lillie</u> Middle <u>MAE</u> Last <u>JOHNSTON</u> | | | | 4. DATE OF DEATH Month <u>MARCH</u> Day <u>26</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"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>JULY 17, 1887</u> | 9. AGE (In years last birthday) <u>71</u> | IF UNDER 1 YEAR Months <u>7</u> Days <u>9</u> | IF UNDER 24 HRS. Hours <u></u> Min. <u></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>Housekeeping</u> | 11. BIRTHPLACE (City and state or country) <u>Candolph County MO</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>USA</u> | |
| 13. FATHER'S NAME <u>EVAN HAINES</u> | | | | 14. MOTHER'S MAIDEN NAME <u>MINNIE CARTER</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 Address <u>EVAN JOHNSTON Versailles, 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>Coronary Occlusion</u> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. } DUE TO (b) <u>Coronary Arteriosclerosis</u> DUE TO (c) <u>4201</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (n) <u>Diabetes Mellitus</u> | | | | | | | INTERVAL BETWEEN ONSET AND DEATH <u>1 hour</u> <u>4 years</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.) | | | | |
| 20c. TIME OF INJURY Hour <u></u> Month, Day, Year <u></u> a. m. <u></u> p. m. <u></u> | | | <u>2</u> | | | | |
| 20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/> | | 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 <u></u> to <u>3-26-58</u> and last saw her ^{him} alive on <u>3-26-58</u> Death occurred at <u>6:20 p.</u> m on the date stated above; and to the best of my knowledge, from the causes stated. | | | | | | | |
| 22a. SIGNATURE <u>Ray F. L. M. D.</u> (Degree or title) | | | | 22b. ADDRESS <u>Versailles, Mo.</u> | | 22c. DATE SIGNED <u>3-27-58</u> | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) | 23b. DATE <u>MARCH 29, 1958</u> | 23c. NAME OF CEMETERY OR CREMATORY <u>CITY CEMETERY</u> | | 23d. LOCATION (City, town, or county) (State) <u>Huntsville, Mo.</u> | | | |
| 24. FUNERAL DIRECTOR <u>JAMES B. SERVINGER Versailles, Mo.</u> | | | ADDRESS | 25. DATE RECD. BY LOCAL REG. <u>3-27-58</u> | 26. REGISTRAR'S SIGNATURE <u>J. L. Hask</u> | | |

(Licensed Embalmer's Statement on Reverse Side)

health, Welfare public service
300 1-56
All diseases in Part I must be causally related. Coroner cannot certify to a death due to natural causes. 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

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APR 17 1958

APR 15 1958

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 *James R. Scriver*

Licensed Embalmer No. *48*

P. O. Address *Verona, N.J.*

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.