

Health, Welfare, Public Service

FILED APR 4 1958

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

58-012861

STATE FILE NUMBER

Registration District No. 338 Primary Registration District No. 3074 Registrar's No. [Signature]

300  
-57

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1. PLACE OF DEATH a. COUNTY <u>SCOTT</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE - <u>MISSOURI</u> b. COUNTY <u>DUNKLIN 0351</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>SIKESTON, MO</u>		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <u>MALDEN</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>SHUFFETT'S N.H.</u>		Length of stay in 1b <u>1 YEAR</u>	d. STREET ADDRESS <u>—</u> (If outside, give location) Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print) First Middle Last <u>AMANDA ELIZABETH WARD</u>			4. DATE OF DEATH Month Day Year <u>MARCH 20 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 21, 1872</u>	9. AGE (In years last birthday) <u>85</u>	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Hours Min.
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>COLEDWATER, MISSOURI</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>
13a. FATHER'S NAME <u>JOHN L. HUFFMAN</u>		13b. MOTHER'S MAIDEN NAME <u>UNKNOWN</u>		14. NAME OF HUSBAND OR WIFE <u>FRED WARD DECEASED</u>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) <u>NO</u>		16. SOCIAL SECURITY NO. <u>NONE</u>	17. INFORMANT Address <u>EDGAR WARD MALDEN, 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>Hydrops of Gall bladder</u> <u>chronic cholecystitis.</u> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. } DUE TO (b) <u>—</u> DUE TO (c) <u>585X</u>		INTERVAL BETWEEN ONSET AND DEATH <u>5 days</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>Gen. Arteriosclerosis, Cystocele, Rectocele, Decubitus Ulcer.</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>0</u>	
20c. TIME OF INJURY Hour Month, Day, Year a.m. 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 COUNTY STATE

21. I attended the deceased from 1957 to 3/20/58 and last saw her alive on 3/18/58  
Death occurred at 1:30 A. m on the date stated above; and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) <u>E. D. Urban M.D.</u>	22b. ADDRESS <u>Sikeston</u>	22c. DATE SIGNED <u>3-22-58</u>
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23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	23b. DATE <u>3-22-58</u>	23c. NAME OF CEMETERY OR CREMATORY <u>BERNIE, CEMETERY</u>	23d. LOCATION (City, town, or county) (State) <u>BERNIE MO.</u>
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24. FUNERAL DIRECTOR <u>DAY FUNERAL HOME</u>	ADDRESS <u>MALDEN, MO</u>	25. DATE RECD. BY LOCAL REG. <u>3-24-58</u>	26. REGISTRAR'S SIGNATURE <u>[Signature]</u>
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(Licensed Embalmer's Statement on Reverse Side)

All diseases in Part I must be causally related.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE  
MEDICAL CERTIFICATION

DATE RECEIVED MAR 31 1958

SCOTT CO. HEALTH DEPT.

CO. FILE NO. 358-81

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. J. Shannon*

Licensed Embalmer No. 4086

P. O. Address Malden

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.