

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

58-012987

STATE FILE NUMBER

FILED MAR 25 1958

Registration District No. 360 Primary Registration District No. 6225 Registrar's No. 36

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-57

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| | | | | | |
|---|------------------------------|---|---|---|---|
| 1. PLACE OF DEATH a. COUNTY <u>Vernon</u> | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Dallas</u> | | |
| b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Nevada, Mo</u> | | Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> | c. CITY OR TOWN <u>Debanon, Mo</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>State Hosp # 3</u> | | Length of stay in lb <u>12-26-56 to 3-16-58</u> | d. STREET ADDRESS (If outside, give location) <u>Brice Route</u> | | Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/> |
| 3. NAME OF DECEASED (Type or print) First Middle Last <u>Margaret Cordelia Jeffries</u> | | | 4. DATE OF DEATH Month Day Year <u>March 16 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>Dec 14, 1900</u> | | 9. AGE (In years last birthday) <u>57</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 | | 11. BIRTHPLACE (City and state or country) <u>Debanon, Mo & U.S. America</u> | |
| 13a. FATHER'S NAME <u>Marshall Ford</u> | | 13b. MOTHER'S MAIDEN NAME <u>Becky Miller</u> | | 14. NAME OF HUSBAND OR WIFE <u>J. A. Jeffries</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>unknown</u> | | 17. INFORMANT <u>J. A. Jeffries</u> Address <u>Debanon, 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> | | | | | INTERVAL BETWEEN ONSET AND DEATH <u>Sudden</u> |
| Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. | | DUE TO (b) <u>Atherosclerosis</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 (a) | | | | | 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 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 <u>12-26-56</u> to <u>3-16-58</u> and last saw her alive on <u>3-17-58</u> Death occurred at _____ m on the date stated above; and to the best of my knowledge, from the causes stated. | | | | | |
| 22a. SIGNATURE (Degree or title) <u>Earl F. Morris, M.D.</u> | | | 22b. ADDRESS <u>Nevada, Mo</u> <u>Nevada State Hosp # 3</u> | | 22c. DATE SIGNED <u>3-16-58</u> |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | | 23b. DATE <u>3-19-1958</u> | 23c. NAME OF CEMETERY OR CREMATORY <u>New Hope cemetery</u> | | 23d. LOCATION (City, town, or county) (State) <u>Dallas Co. Mo</u> |
| 24. FUNERAL DIRECTOR <u>L. B. Jones</u> | | | 25. DATE RECD. BY LOCAL REG. <u>3-18-1958</u> | | 26. REGISTRAR'S SIGNATURE <u>Anna E. Ferry</u> |

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE
MEDICAL CERTIFICATION

All diseases in Part I must be causally related.

JAN 7 1959

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 me....., Student Embalmer No. ✓ working under my personal supervision.

Student ✓.....
Signature of Student Embalmer

Signed R. E. Cheatham.....

Licensed Embalmer No. 3813.....

P. O. Address Buffalo, N.Y......

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.