

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

58-013438  
STATE FILE NUMBER

FILED APR 21 1958

Registration District No. 47 Primary Registration District No. 2008 Registrar's No. 85

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.  
USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE  
Doctor, coroner, etc. must use only standard nomenclature in item 10. No symptoms will be listed.

|  |                                  |   |   |   |   |
|--|----------------------------------|---|---|---|---|
| 1. PLACE OF DEATH<br>a. COUNTY <u>Callaway</u>   |                                  |   | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <u>Missouri</u> b. COUNTY <u>Callaway</u> |   |   |
| b. CITY (If outside corporate limits, give TOWNSHIP only)<br>OR <u>Fulton</u><br>TOWN  |                                  | Inside Limits<br>Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>  | c. CITY OR TOWN <u>Fulton</u>   |   | Inside Limits<br>Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>              |
| c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>222 E. 6th St</u>   |                                  | Length of stay in 1b <u>4 Mo.</u>   | d. STREET ADDRESS (If outside, give location) <u>416 N.W. 9th St</u>  |   | Reside on Farm<br>Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>             |
| 3. NAME OF DECEASED (Type or print)<br>First <u>Lucy</u> Middle <u>Ann</u> Last <u>Jefferson</u>   |                                  |   | 4. DATE OF DEATH<br>Month <u>April</u> Day <u>15</u> Year <u>1958</u>   |   |   |
| 5. SEX <u>Female</u>   | 6. COLOR OR RACE <u>Negro</u>    | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>Sept, 13, 1867</u>  | 9. AGE (In years last birthday) <u>90</u>                         | IF UNDER 1 YEAR<br>Months <u>0</u> Days <u>0</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>Home</u>   | 11. BIRTHPLACE (City and state or country) <u>Mokane, Missouri</u>  |   | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>  |
| 13. FATHER'S NAME <u>Kipp Moore</u>  |                                  |   | 14. MOTHER'S MAIDEN NAME <u>Ann Kirby</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>Margie Moore</u> <u>416 N.W. 9th St. Fulton, Mo.</u>   |   |   |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>CEREBRAL HEMORRHAGE</u>  |                                  |   |   |   | INTERVAL BETWEEN ONSET AND DEATH<br><u>HOURS</u>  |
| Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.   |                                  |   |   |   | DUE TO (b) <u>CEREBRAL ATHEROSCLEROSIS</u>  |
|  |                                  |   |   |   | DUE TO (c) <u>331X</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?<br>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.)  |   |   |   |
| 20c. TIME OF INJURY<br>Hour <u>10:00</u> a. m. <u>PM</u> Month, Day, Year  |                                  |   |   |   |   |
| 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>Jan 1956</u> to <u>death</u> and last saw her alive on <u>4-14-58</u><br>Death occurred at <u>10:00</u> <u>PM</u> m on the date stated above; and to the best of my knowledge, from the causes stated. |                                  |   |   |   |   |
| 22a. SIGNATURE (Degree or title)<br><u>Tom Brewer MD</u>   |                                  |   | 22b. ADDRESS<br><u>Fulton, Mo.</u>  |   | 22c. DATE SIGNED<br><u>4-17-58</u>  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><u>Burial</u>   | 23b. DATE<br><u>Apr-20, 1958</u> | 23c. NAME OF CEMETERY OR CREMATORY<br><u>South Side Cemetery</u>  |   | 23d. LOCATION (City, town, or county) (State)<br><u>Fulton Mo</u> |   |
| 24. FUNERAL DIRECTOR<br><u>Wallace Funeral Home Fulton, Mo.</u>  |                                  | ADDRESS   | 25. DATE RECD. BY LOCAL REG.<br><u>April 18-1958</u>  | 26. REGISTRAR'S SIGNATURE<br><u>Narretta Lawrence</u>             |   |

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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 *Hector R. Masure*

Licensed Embalmer No. *49*

P. O. Address *Fuller*

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.