

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

58-013684

STATE FILE NUMBER

FILED MAY 6 1958

Registration District No. 93 Primary Registration District No. 5331 Registrar's No. 58-30

0290  
300  
1-56  
0290  
USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE  
478  
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.

1. PLACE OF DEATH a. COUNTY <u>DADE</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Mo</u> b. COUNTY <u>Dade</u>				
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Cedar</u>		Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>		c. CITY OR TOWN <u>Jerico sprg</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			Length of stay in 1b <u>40 yrs</u>		d. STREET ADDRESS (If outside, give location) <u>5 R. W. Jerico</u>		Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>SARAH</u> - Middle <u>JANE</u> - Last <u>HIGGINS</u>				4. DATE OF DEATH Month <u>4</u> - Day <u>21</u> - Year <u>1958</u>				
5. SEX <u>F.</u>	6. COLOR OR RACE <u>W</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>6-30-1872</u>		9. AGE (In years last birthday) <u>85</u>	IF UNDER 1 YEAR Months <u>9</u> Days <u>21</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>housekeeper</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>Housekeeping</u>		11. BIRTHPLACE (City and state or country) <u>BARTON-County, Mo. U.S.A.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>JOEL C. DUNCAN</u>				14. MOTHER'S MAIDEN NAME <u>EASTER JONES</u>				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>None</u>			16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT <u>Eva Mitchell, Jerico sprg. Mo</u>			Address
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>MYO CARDIAL INFARCTION</u> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. } DUE TO (b) <u>MYOCARDITIS</u> DUE TO (c) <u>Chronic NEPHRITIS</u>							INTERVAL BETWEEN ONSET AND DEATH <u>1 Day</u> <u>6 mo</u> <u>3 yrs</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>592X</u>					
20c. TIME OF INJURY Hour <u></u> Month, Day, Year a. m. <u></u> p. m. <u></u>			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>9-56</u> to <u>4-21-58</u> and last saw her <u>alive</u> on <u>21</u> Death occurred at <u>806 A</u> m on the date stated above; and to the best of my knowledge, from the causes stated.								
22a. SIGNATURE (Degree or title) <u>J. Bannister M.D.</u>				22b. ADDRESS <u>JERICO SPRINGS</u>			22c. DATE SIGNED <u>4-20-58</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE <u>4-23-1958</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Shenfeld Cem.</u>		23d. LOCATION (City, town, or county) (State) <u>3 1/2 S. W. Jerico sprg. Mo</u>			
24. FUNERAL DIRECTOR <u>Dr. P. Long, Jerico sprg. Mo</u>			ADDRESS <u>Jerico sprg. Mo</u>		25. DATE RECD. BY LOCAL REG. <u>4/29/58</u>		26. REGISTRAR'S SIGNATURE <u>J. C. Casada</u>	

(Licensed Embalmer's Statement on Reverse Side)

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.....  
*R. D. Long*

Licensed Embalmer No. *37*

P. O. Address.....  
*Glenn*

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.