

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

58-014756

STATE FILE NUMBER

FILED APR 17 1958

Registration District No. 160 Primary Registration District No. 559V Registrar's No. 581

300
1-56

All diseases in Part I must be causally related. Coroner cannot certify to a death due to natural causes. No symptoms will be listed.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

0500
4

1. PLACE OF DEATH a. COUNTY <u>JEFFERSON</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MO</u> b. COUNTY <u>St Louis</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>FESTUS-RURAL</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		c. CITY OR TOWN <u>MAPLE WOOD</u> <u>4524</u> 0 Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>MOUNTAIN VIEW</u> Length of stay in 1b <u>None</u>		d. STREET ADDRESS (If outside, give location) <u>2200 BREDELL</u> Reside on Form Yes <input type="checkbox"/> No <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>ANICE</u> Middle <u>E.</u> Last <u>LOFLIN</u>			4. DATE OF DEATH Month <u>APRIL</u> Day <u>6</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>Aug 24, 1877</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>None</u>	9. AGE (In years last birthday) <u>80</u> IF UNDER 1 YEAR Months <u>1</u> IF UNDER 24 HRS. Days <u>1</u> Hours <u>1</u> Min. <u>1</u>
11. BIRTHPLACE (City and state or country) <u>Tenn</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>JOHN SHORT</u>		14. MOTHER'S MAIDEN NAME <u>ALICE SHORT</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>None</u>	
17. INFORMANT <u>MRS DYER GARDNER</u> Address <u>Sikeston, 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 Thrombosis</u> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. } DUE TO (b) _____ DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>4201</u>			INTERVAL BETWEEN ONSET AND DEATH <u>few min. ONLY</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 _____ 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 <u>4201</u> COUNTY _____ STATE _____	
21. I attended the deceased from <u>1-29-55</u> to <u>4-6-58</u> and last saw her ^{alive} on <u>4-6-58</u> Death occurred at <u>2:10 P. m.</u> on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE <u>R. H. D. [Signature]</u> (Degree or title)		22b. ADDRESS <u>Crystal City, Mo.</u>	
		22c. DATE SIGNED <u>4-7-58</u>	
23a. BURIAL, CREMATION, or other disposal (Specify) <u>Burial</u>		23b. DATE <u>4/9/58</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>MAPLE GROVE Cem</u>		23d. LOCATION (City, town, or county) (State) <u>BLYTHEVILLE ARK</u>	
24. FUNERAL DIRECTOR <u>MAHN FUNERAL HOME</u> ADDRESS <u>20550, 7th</u>		25. DATE RECD. BY LOCAL REG. <u>4-7-58</u>	
		26. REGISTRAR'S SIGNATURE <u>[Signature]</u>	

JEFFERSON COUNTY HEALTH DEPT.
HILLSBORO, MISSOURI

DATE RECEIVED

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 embalmed
by me, or by, Student Embalmer No.
working under my personal supervision..

Student.....
Signature of Student Embalmer

Signed *Serald J. Mahan*
.....

Licensed Embalmer No. *49*

P. O. Address *De Soto*

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.