Health, Welfare Public Service

300
1-57

THE DIVISION OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

58-021154
STATE FILE NUMBER

FILED JUN 24 1958

Registration District No. 49 Primary Registration District No. 5174 Registrar's No. 10

1. PLACE OF DEATH
a. COUNTY: CAMDEN
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN: Climax Springs — Inside Limits: Yes ☐ No ☒
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION: — Length of stay in Ib: Life

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Missouri b. COUNTY: CAMDEN
c. CITY OR TOWN: Climax Springs — Inside Limits: Yes ☐ No ☒
d. STREET ADDRESS (If outside, give location): — Reside on Farm: Yes ☒ No ☐

3. NAME OF DECEASED (Type or print) First: NELLIE Middle: JANE Last: CROUCH

4. DATE OF DEATH Month: June Day: 11 Year: 1958

5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH: Sept 17, 1876
9. AGE (In years last birthday): 81 — IF UNDER 1 YEAR: Months: 8 Days: 27 — IF UNDER 24 HRS.: Hours: Min.:

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife
10b. KIND OF BUSINESS OR INDUSTRY: Home
11. BIRTHPLACE (City and state or country): Ark.
12. CITIZEN OF WHAT COUNTRY? U.S.A

13a. FATHER'S NAME: Benj Butts
13b. MOTHER'S MAIDEN NAME: Susie Powers.
14. NAME OF HUSBAND OR WIFE: deceased.

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No (If yes, give war or dates of service): No
16. SOCIAL SECURITY NO.: None
17. INFORMANT: W. B. Crouch Address: Climax Springs, Mo

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Bronchopneumonia — INTERVAL BETWEEN ONSET AND DEATH: 1 week
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.
DUE TO (b) multiple cerebral thrombi — 1 year
DUE TO (c) 332XA
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a): Hypertension, Tuberculosis

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT ☐ SUICIDE ☐ HOMICIDE ☐
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)
20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year
20d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
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 Jan 57, to June 1958 and last saw her alive on June 8 1958
Death occurred at 4:30 A. m on the date stated above; and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title): Jack Gunn M.D.
22b. ADDRESS: Versailles, Mo.
22c. DATE SIGNED: June 12 1958

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE: June 14, 1958
23c. NAME OF CEMETERY OR CREMATORY: Cable Ridge Cemetery
23d. LOCATION (City, town, or county) (State): Camden Co. Mo

24. FUNERAL DIRECTOR: John L Reser ADDRESS: Warsaw
25. DATE RECD. BY LOCAL REG.: June 18 1958
26. REGISTRAR'S SIGNATURE: Cilda R. Eldred

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

All diseases in Part I must be causally related.

(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 John 7 Rise

Licensed Embalmer No. 4098

P. O. Address Warsaw

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.