

All diseases in Part I must be causally related. Coroner cannot certify to a death due to natural causes. Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed.

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

58-021509

STATE FILE NUMBER

FILED JUN 30 1958

Registration District No. 120 Primary Registration District No. 4197 Registrar's No. 222

1. PLACE OF DEATH a. COUNTY <u>GENTRY</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MISSOURI</u> COUNTY <u>GENTRY</u>			
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>STANBERRY</u>			Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <u>STANBERRY</u>		0380 Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>REST HAVEN</u>			Length of stay in lb <u>1 1/2 yrs.</u>	d. STREET ADDRESS <u>1st & High St.</u>			Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <u>LILLIE</u> Middle <u>F.</u> Last <u>STUART</u>				4. DATE OF DEATH Month <u>June</u> Day <u>18</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>NOV. 1, 1884</u>	9. AGE (In years last birthday) <u>73</u> IF UNDER 1 YEAR: Months <u>0</u> Days <u>0</u> Hours <u>0</u> Min. <u>0</u> IF UNDER 24 HRS. 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>NEAR STANBERRY, MO</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		
13. FATHER'S NAME <u>ROBERT WOOD</u>			14. MOTHER'S MAIDEN NAME <u>ELIZA LILLIE</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 Address <u>E. A. STUART MOBERLY, 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>Severe Anemia</u> DUE TO (b) <u>gastro intestinal hemorrhage</u> DUE TO (c) <u>undetermined</u> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Arterio - vascular arteriosclerosis; Chronic primary infection</u>						INTERVAL BETWEEN ONSET AND DEATH <u>2 days</u> <u>2 days</u> <u>578X</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 of Part of item 18.)				
20c. TIME OF INJURY Hour <u>6:12 p.m.</u> Month <u>June</u> Day <u>10</u> Year <u>1958</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>June 10, 1958</u> to <u>June 18, 1958</u> and last saw her alive on <u>June 18, 1958</u> Death occurred at <u>6:12 p.m.</u> on the date stated above, and to the best of my knowledge, from the causes stated.							
22a. SIGNATURE (Degree or title) <u>Arthur P. Carlin, MD</u>				22b. ADDRESS <u>Stanberry, Mo</u>		22c. DATE SIGNED <u>6-20-58</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City, town, or county)		(State)	
<u>Burial</u>	<u>June 20, 1958</u>	<u>HIGH RIDGE</u>		<u>STANBERRY MO</u>			
24. FUNERAL DIRECTOR ADDRESS <u>Johnson Funeral Home</u>			25. DATE RECD. BY LOCAL REG. <u>6-22-58</u>	26. REGISTRAR'S SIGNATURE <u>Mo. L. W. Bare</u>			

(Licensed Embalmer's Statement on Reverse Side)

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

542

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 *Loss E. ...*

Licensed Embalmer No. *419*

P. O. Address *St. Louis*

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.