

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

58-022487

STATE FILE NUMBER

FILED JUN 16 1958 Registration District No. 184 Primary Registration District No. 3038 Registrar's No. 66

1. PLACE OF DEATH a. COUNTY <b>Linn</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Missouri</b> b. COUNTY <b>Linn</b>					
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>Brookfield</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		c. CITY OR TOWN <b>Brookfield</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>			
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>Cramer Conv. Home</b>			Length of stay in 1b <b>30 yrs</b>		d. STREET ADDRESS <b>815 Snow Street</b>		(If outside, give location) Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First <b>ANNA</b> Middle <b>ZOE</b> Last <b>DOWNEY</b>				4. DATE OF DEATH Month <b>June</b> Day <b>8</b> Year <b>1958</b>					
5. SEX <b>F</b>	6. COLOR OR RACE <b>W</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>Apr. 22, 1881</b>		9. AGE (In years last birthday) <b>77</b>	IF UNDER 1 YEAR Months _____ Days _____	IF UNDER 24 HRS. Hours _____ Min. _____	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Registered nurse, ret.</b>			10b. KIND OF BUSINESS OR INDUSTRY <b>Hospitals</b>		11. BIRTHPLACE (City and state or country) <b>Marceline, Mo.</b>		12. CITIZEN OF WHAT COUNTRY? <b>US</b>		
13. FATHER'S NAME <b>Warren Wolfe</b>				14. MOTHER'S MAIDEN NAME <b>Sarah Ellen Buck</b>					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO.		17. INFORMANT <b>Jasper Wolfe, Brookfield, Mo.</b>					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral embolism</b>							INTERVAL BETWEEN ONSET AND DEATH <b>3 days</b>		
Conditions, if any, which gave rise to above cause - (a), stating the underlying cause last.		DUE TO (b) <b>Myocardial infarction with mural thrombi</b>					DUE TO (c) <b>Arteriosclerosis</b>		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <b>Complete heart block (A-V) with idiopathic atrial rhythm</b>							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)						
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 <b>Brookfield Mo</b>		COUNTY		STATE	
21. I attended the deceased from <b>Aug 1957</b> to <b>June 8, 1958</b> and last saw her <sup>alive</sup> on <b>June 7, 1958</b> Death occurred at <b>1:50 p</b> m on the date stated above; and to the best of my knowledge, from the causes stated.									
22a. SIGNATURE <b>J. R. Johnson</b> (Degree or title)				22b. ADDRESS <b>Brookfield Mo</b>			22c. DATE SIGNED <b>6-9-58</b>		
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE	23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City, town, or county) (State)				
<b>Burial</b>		<b>June 10, 1958</b>	<b>Mt. Olivet Cem.</b>		<b>Marceline, Mo.</b>				
24. FUNERAL DIRECTOR <b>Wright Funeral Home, Brookfield, Mo.</b>				25. DATE RECD. BY LOCAL REG. <b>6-10-58</b>		26. REGISTRAR'S SIGNATURE <b>Katharine Johnson</b> Dep.			

(Licensed Embalmer's Statement on Reverse Side)

Health, & Welfare Public Service

300 1-56

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.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

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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..... *Harold B. Wright* .....

Licensed Embalmer No. .... 37

P. O. Address..... Brookfield,

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.