

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

58-024806
STATE FILE NUMBER

FILED JUL 22 1958 Registration District No. 47 Primary Registration District No. 4067 Registrar's No. 164

1. PLACE OF DEATH a. COUNTY <u>Callaway</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Callaway</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Andrews MO.</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		c. CITY OR TOWN <u>Andrews MO.</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>Home</u> Length of stay in 1b <u>40 years</u>		d. STREET ADDRESS (If outside, give location) Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>	

3. NAME OF DECEASED (Type or print) <u>ANNIE BELL FOLKEST</u> <small>First Middle Last</small>			4. DATE OF DEATH <u>July 16-1958</u> <small>Month Day Year</small>		
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"/> 2 DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>JUNE 17-1894</u>	9. AGE (In years last birthday) <u>64</u> <small>IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.</small>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>COOK</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Cook.</u>	11. BIRTHPLACE (City and state or country) <u>Missouri</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>
13. FATHER'S NAME <u>ARTHUR VANES</u>			14. MOTHER'S MAIDEN NAME <u>OK</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>495-12-1980</u>	17. INFORMANT <u>ANNIE MAE WILKINSON</u> <small>Address</small>		

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>CEREBRO VASCULAR ACCIDENT</u>		INTERVAL BETWEEN ONSET AND DEATH <u>1 HOUR</u>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. } DUE TO (b) _____		331X
DUE TO (c) _____		
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 type="checkbox"/> <u>0</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 _____ 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 COUNTY STATE
21. I attended the deceased from <u>1957</u> to <u>JULY, 1958</u> and last saw ^{her} _{him} alive on <u>JULY 6, 58</u> Death occurred at <u>10:00 P</u> m on the date stated above; and to the best of my knowledge, from the causes stated.		
22a. SIGNATURE (Degree or title) <u>James E. Hill MD</u>	22b. ADDRESS <u>607 Court Fulton, Mo</u>	22c. DATE SIGNED <u>7-19-58</u>

23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE <u>7-21-1958</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Yucatan Cem</u>	23d. LOCATION (City, town, or county) (State) <u>S. E Callaway Co Mo</u>
24. FUNERAL DIRECTOR <u>Mrs Stuart Parker, Columbia Mo.</u> ADDRESS	25. DATE RECD. BY LOCAL REG. <u>July-19-1958</u>	26. REGISTRAR'S SIGNATURE <u>Maretha Lawrence</u>	

(Licensed Embalmer's Statement on Reverse Side)

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

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

Health, Welfare Public Service
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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 *Gayett Green*

Licensed Embalmer No. *47*

P. O. Address *Marshall*

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (F 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.