

Health,
Welfare
Public
Service

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

58-026655
STATE FILE NUMBER

HELD AUG 15 1958 Registration District No. 314 Primary Registration District No. 4459 Registrar's No. 42

1. PLACE OF DEATH a. COUNTY <u>ST CLAIR</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>ST CLAIR</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>OSCEOLA rural</u>		Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	c. CITY OR TOWN <u>OSCEOLA 0930</u> Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>OSCEOLA TOWNSHIP</u>		Length of stay in 1b	d. STREET ADDRESS (If outside, give location) <u>OSCEOLA TOWNSHIP</u> Reside on Farm Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>

3. NAME OF DECEASED (Type or print) First <u>ANNIE</u> Middle <u>Decker</u> Last <u>Decker</u>			4. DATE OF DEATH Month <u>July</u> Day <u>12</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>Dec 21, 1861</u>	9. AGE (In years last birthday) <u>96</u>	IF UNDER 1 YEAR Months <u>0</u> Days <u>0</u> 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>Nurse</u>		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and state or country) <u>Missouri</u>		12. CITIZEN OF WHAT COUNTRY?

13a. FATHER'S NAME <u>Dannan</u>		13b. MOTHER'S MAIDEN NAME <u>?</u>	14. NAME OF HUSBAND OR WIFE <u>deceased - Fredy Osceola</u>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war and dates of service)		16. SOCIAL SECURITY NO. <u>?</u>	17. INFORMANT <u>Social Welfare Office</u> Address		

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>Arteriosclerotic Heart Disease</u>				INTERVAL BETWEEN ONSET AND DEATH <u>1 year</u>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) <u>Generalized arteriosclerosis</u>		20 years	
	DUE TO (c) <u>4200</u>			
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 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 <u>?</u> Month <u>?</u> Day <u>?</u> Year <u>?</u> a.m. <u>?</u> p.m. <u>?</u>					
20d. INJURY OCCURRED WHILE AT <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 October 1957 to July 12, 1958 and last saw her ^{her} alive on July 11, 1958 on the ? date stated above; and to the best of my knowledge, from the causes stated.

22a. SIGNATURE <u>Herbert M. Mason</u> (Degree or title) <u>MD</u>	22b. ADDRESS <u>Osceola Mo</u>	22c. DATE SIGNED <u>July 1958</u>
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23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE <u>7-14-58</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Osceola Osceola</u>	23d. LOCATION (City, town, or country) <u>Osceola</u> (State)
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24. FUNERAL DIRECTOR <u>Charles Stone</u>	ADDRESS <u>Osceola Mo</u>	25. DATE RECD. BY LOCAL REG. <u>Aug 8 - 1958</u>	26. REGISTRAR'S SIGNATURE <u>Ruth Seavers</u>
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(Licensed Embalmer's Statement on Reverse Side)

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

All diseases in Part I must be causally related.

58

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 *J. B. Goodrich*

Licensed Embalmer No. *3038*

P. O. Address *Oreola, Mo.*

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.