

Health,
& Welfare
Public
Service
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THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

58-027934

STATE FILE NUMBER

FILED JUL 23 1958

Registration District No. 340 Primary Registration District No. 3075 Registrar's No. 56

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|--|----------------------------------|---|---|
| 1. PLACE OF DEATH a. COUNTY Stoddard | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY Stoddard | |
| b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Dexter | | Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> | c. CITY OR TOWN Dexter <u>10310</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 1415 E. Stoddard | | Length of stay in lb life | d. STREET ADDRESS (If outside, give location) 1415 E. Stoddard Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> |
| 3. NAME OF DECEASED (Type or print) First Mary Middle Ellen Last Keck | | | 4. DATE OF DEATH Month July Day 11 Year 1958 |
| 5. SEX female | 6. COLOR OR RACE white | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH Sept. 23, 1874 |
| 9. AGE (In years last birthday) 83 | | IF UNDER 1 YEAR Months 3 Days 10 | IF UNDER 24 HRS. Hours 0 Min. 0 |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife | | 10b. KIND OF BUSINESS OR INDUSTRY housewife | 11. BIRTHPLACE (City and state or country) Bloomfield, Mo. |
| 12. CITIZEN OF WHAT COUNTRY? U.S.A. | | 13a. FATHER'S NAME Jesse Bolin | |
| 13b. MOTHER'S MAIDEN NAME Francis Triplett | | 14. NAME OF HUSBAND OR WIFE deceased | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no | | 16. SOCIAL SECURITY NO. X X X X X X X X X X | 17. INFORMANT Fannie Rankins Address Dexter, Mo. |
| 18. CAUSE OF DEATH (Enter one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Congestive heart failure | | | INTERVAL BETWEEN ONSET AND DEATH 3 mo |
| Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) Atherosclerosis | | | 10 years |
| DUE TO (c) Chronic bronchitis | | | 2 years |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) Cholelithiasis - cirrhosis of liver | | | 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.) 4500 | |
| 20c. TIME OF INJURY Hour 5:45 Month July Day 11 Year 1958 a.m. A. 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 Dexter, Mo. |
| 20g. COUNTY Stoddard | | 20h. STATE Missouri | |
| 21. I attended the deceased from June 1957 to July 11 1958 and last saw her/him alive on July 10 1958 Death occurred at 1415 E. Stoddard on the date stated above; and to the best of my knowledge, from the causes stated. | | | |
| 22a. SIGNATURE C. C. Cooney, M.D. (Degree or title) | | 22b. ADDRESS Dexter, Mo. | 22c. DATE SIGNED 7/12/58 |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) burial | 23b. DATE 7-13-58 | 23c. NAME OF CEMETERY OR CREMATORY Bloomfield cemetery | 23d. LOCATION (City, town, or country) Bloomfield, Mo. (State) |
| 24. FUNERAL DIRECTOR Watkins & Sons ADDRESS Dexter, Mo. | | 25. DATE RECD. BY LOCAL REG. 7/17/58 | 26. REGISTRAR'S SIGNATURE Delma V. Jenkins |

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

All diseases in Part I must be causally related. All diseases in Part II must be causally related. No symptoms will be listed.

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 *Marsh W. Dennis*

Licensed Embalmer No. *4717*

P. O. Address *Perth Amoy*

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.