

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

58-028984

STATE FILE NUMBER

FILED AUG 18 1958

Registration District No. 143 Primary Registration District No. 5561 Registrar's No. 23

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. Caretaker cannot certify to a death due to natural causes.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

| | | | | | | | | | |
|--|----------------------------------|---|---|---|--|--|--|---|--|
| 1. PLACE OF DEATH a. COUNTY Howell | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY Howell | | | | | |
| b. CITY (If outside corporate limits, give TOWNSHIP only) TOWN Siloam Springs, Mo. | | Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> | | c. CITY OR TOWN Willow Springs, | | Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> | | | |
| c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Pine Brook Rest | | | Length of stay in 1b Home 5 mo. | | 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) First NANCY Middle ANN Last SCARBROUGH | | | | 4. DATE OF DEATH Month July Day 25 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"/> 2 DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH Aug. 12, 1878 | | 9. AGE (In years last birthday) 79 | | IF UNDER 1 YEAR Months 11 Days 13 Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife | | | 10b. KIND OF BUSINESS OR INDUSTRY home | | 11. BIRTHPLACE (City and state or country) Missouri | | 12. CITIZEN OF WHAT COUNTRY? USA | | |
| 13. FATHER'S NAME unknown | | | | 14. MOTHER'S MAIDEN NAME unknown | | | | | |
| 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. none | | 17. INFORMANT Address Mrs. Alfred Squires West Plains, Mo. | | | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Generalized Arteriosclerotic Heart Disease DUE TO (b) Paroxysmal Atrial Fibrillation, Senility DUE TO (c) Decubitus Ulcers - Sacrum & Lt Ankle PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 4200 | | | | | | | | INTERVAL BETWEEN ONSET AND DEATH 2 | |
| 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.) 4200 | | | | | | |
| 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 | | COUNTY | | STATE | |
| 21. I attended the deceased from 4 Mar 1958 to 25 July 1958 and last saw her alive on 13 July 1958 Death occurred at 0145 A. m. on the date stated above; and to the best of my knowledge, from the causes stated. | | | | | | | | | |
| 22a. SIGNATURE (Degree, if M.D.) Dr. Rollin Smith MD | | | | 22b. ADDRESS West Plains, Mo. | | 22c. DATE SIGNED 6 Aug 58 | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 23b. DATE 7/27/58 | 23c. NAME OF CEMETERY OR CREMATORY Pine Grove | | 23d. LOCATION (City, town, or county) (State) Howell County, Mo. | | | | |
| 24. FUNERAL DIRECTOR ADDRESS Burns Willow Springs, Mo. | | | | 25. DATE RECD. BY LOCAL REG. 8/16/58 | | 26. REGISTRAR'S SIGNATURE Marshall Ballard | | | |

(Licensed Embalmer's Statement on Reverse Side)

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was em-
by me, or by, Student Embalmer No.....
working under my personal supervision..

Student.....
Signature of Student Embalmer

Fred W. Barnes
Signed.. Fred.. W.. Barnes.....

Licensed Embalmer No.. 461.

P. O. Address Willow Spring

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.