

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

58-031594
STATE FILE NUMBER

FILED SEP 22 1958 Registration District No. 1 Primary Registration District No. 300 Registrar No. 290

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|---|--|--|---|
| 1. PLACE OF DEATH a. COUNTY ADAIR | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE IOWA b. COUNTY Lee | |
| b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN KIRKSVILLE | | Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> | c. CITY OR TOWN FORT MADISON 2140 Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> |
| c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION K. O. H. | | Length of stay in lb | |
| | | d. STREET ADDRESS 504 8th Street (If outside, give location) Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> | |

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|--|----------------------------------|---|---|--|--|
| 3. NAME OF DECEASED (Type or print) First MAY BELLE Middle M. Last MORRIS | | | 4. DATE OF DEATH Month SEPT. Day 13 Year 1958 | | |
| 5. SEX Female | 6. COLOR OR RACE White | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH May 8, 1894 | 9. AGE (In years last birthday) 64 IF UNDER 1 YEAR Months Days 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 Own Home | 11. BIRTHPLACE (City and state or country) Leocompton, Kansas | | 12. CITIZEN OF WHAT COUNTRY? USA |
| 13. FATHER'S NAME Cyrus Glenn | | | 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 Ira A. Morris, Fort Madison Address | | |

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|---|---|---|
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary artery occlusion | | INTERVAL BETWEEN ONSET AND DEATH 10 min |
| Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. | DUE TO (b) Coronary artery sclerosis | years |
| | DUE TO (c) 4201H | |

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)
Carcinoma of breast with Metastasis to spine

| | | |
|---|--|---|
| 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 COUNTY STATE |

21. I attended the deceased from **2-05-1953** to **Sept 13 '58** and last saw her alive on **Sept 13, 1958**
Death occurred at **2:05 p** m on the date stated above; and to the best of my knowledge, from the causes stated.

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| 22a. SIGNATURE (Degree or title) M. D. Gutierrez MD | 22b. ADDRESS Kirkville Mo | 22c. DATE SIGNED 9-13-58 |
|---|-------------------------------------|------------------------------------|

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|---|------------------------------------|--|--|
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Cremation | 23b. DATE Sept. 18, 1958 | 23c. NAME OF CEMETERY OR CREMATORY Mount Cremona | 23d. LOCATION (City, town, or county) (State) Denverport, Iowa |
|---|------------------------------------|--|--|

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| 24. FUNERAL DIRECTOR Barr Memorial Chapel | ADDRESS Fort Madison | 25. DATE RECD. BY LOCAL REG. 9-13-1958 | 26. REGISTRAR'S SIGNATURE Doris W. Rathoff |
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(Licensed Embalmer's Statement on Reverse Side)

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

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.

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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 *James W. Bove*

Licensed Embalmer No. 29-

P. O. Address *Illinois*

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.