

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

58-033928
STATE FILE NUMBER

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 casually related. Coroner cannot certify to a death due to natural causes.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

FILED OCT 7 1958 Registration District No. 316 Primary Registration District No. 6075 Registrar's No. 369

1. PLACE OF DEATH a. COUNTY ST. FRANCOIS COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MISSOURI b. COUNTY ST. FRANCOIS	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN RURAL ST. FRANCOIS Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>		c. CITY OR TOWN BISMARCK Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION MINERAL AREA OSTEOPATHIC HOSH. Length of stay in lb 3 da		d. STREET ADDRESS (If outside, give location) ROUTE #1 Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First MARY Middle Last CROWDER			4. DATE OF DEATH Month Day Year SEPT. 27 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 AUG. 10, 1882 76
9a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) at home		10b. KIND OF BUSINESS OR INDUSTRY own home	9. AGE (In years last birthday) Months Days Hours Min. 76
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) at home		11. BIRTHPLACE (City and state or country) SPRINGFIELD, MISSOURI	12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME John Hamilton		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. no	17. INFORMANT Address John Crowder, Bismarck 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) <i>Acute pulmonary edema</i> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <i>Rheumatic heart disease</i> DUE TO (c) <i>416 X</i> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			INTERVAL BETWEEN ONSET AND DEATH <i>Several hours</i> <i>years</i>
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 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 <i>9/24/58</i> to <i>9/27/58</i> and last saw her alive on <i>9/27/58</i> Death occurred at <i>10:14 pm</i> on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Doctor or title) <i>M.A. Kahlberg MD</i>		22b. ADDRESS <i>Flat River Mo</i>	22c. DATE SIGNED <i>9/28/58</i>
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>burial</i>	23b. DATE <i>9-30-58</i>	23c. NAME OF CEMETERY OR CREMATORY <i>Masonic Cemetery</i>	23d. LOCATION (City, town, or county) (State) <i>Bismarck Mo</i>
24. FUNERAL DIRECTOR ADDRESS <i>White Funeral Home, Ironton Mo.</i> <i>Archie White</i>		25. DATE RECD. BY LOCAL REG. <i>Sept. 28, 1958</i>	26. REGISTRAR'S SIGNATURE <i>Ether Rudloff</i>

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 *Amel J. White*.....

Licensed Embalmer No *7012*

P. O. Address *Dorchester, Mass*

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