

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

58-035176

STATE FILE NUMBER

FILED SEP 24 1958 Registration District No. 325 Primary Registration District No. 4478 Registrar's No. 77

1. PLACE OF DEATH a. COUNTY Schuyler				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY Schuyler			
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Lancaster		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		c. CITY OR TOWN Lancaster		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) INSTITUTION Home			Length of stay in 1b <i>Life</i>		d. STREET ADDRESS (If outside, give location)		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Amy Elizabeth Maize				4. DATE OF DEATH Month Sept. 14, 1958			
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Sept. 10, 1873		9. AGE (In years last birthday) 85	IF UNDER 1 YEAR Months 4	IF UNDER 24 HRS. Days 0 Hours 0 Min. 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housekeeper		10b. KIND OF BUSINESS OR INDUSTRY None		11. BIRTHPLACE (City and state or country) Schuyler Co., Mo.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME John R. Maize				14. MOTHER'S MAIDEN NAME Susan Amanda Reed			
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. Hardin Graves, Lancaster, 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) Acute circulatory failure Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. } DUE TO (b) Congestive Heart failure DUE TO (c) Hypertensive Cardiovascular disease PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Carcinoma of breast in 1956.							INTERVAL BETWEEN ONSET AND DEATH 2 years Year
19a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>			19b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 443XH				
20c. TIME OF INJURY Hour 9:45 Month, Day, Year							
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 12-21-56 to 9-14-58 and last saw her alive on 9-14-58 Death occurred at 9:45 A. M. on the date stated above; and to the best of my knowledge, from the causes stated.							
22a. SIGNATURE (Degree or title) W. Stoker, M.D.				22b. ADDRESS Lancaster, Mo.		22c. DATE SIGNED 9-17-58	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE Sept. 16, 58	23c. NAME OF CEMETERY OR CREMATORY Lancaster I.O.O.F.		23d. LOCATION (City, town, or county) (State) Lancaster, Missouri		
24. FUNERAL DIRECTOR Norman Funeral Home, Lancaster, Mo.				25. DATE RECD. BY LOCAL REG. 9-16-58		26. REGISTRAR'S SIGNATURE W. R. Stoker	

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

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

1000-87

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 *Donald L. Foster*.....

Licensed Embalmer No. *479*

P. O. Address *Luskville*

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.