

Health,
& Welfare
Public
Service

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

58-035284

STATE FILE NUMBER

FILED SEP 17 1958 Registration District No. 360 Primary Registration District No. 6225 Registrar's No. 127

300
1-57

1. PLACE OF DEATH a. COUNTY <i>Kernon</i>			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Missouri</i> b. COUNTY <i>Barry</i>		
b. CITY (If outside corporate limits, give TOWNSHIP only) <i>Washington Township</i>		Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	c. CITY OR TOWN <i>Monett 0050</i>		Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
c. FULL NAME OF (If not in hospital, give location) HOSPITAL OR INSTITUTION <i>State Hospital #3</i>			Length of stay in lb <i>10 yrs 10 1/2 mos.</i>		d. STREET ADDRESS (If outside, give location) <i>unknown - rural</i>
3. NAME OF DECEASED (Type or print) First <i>WILLIAM</i> Middle <i>M.</i> Last <i>LUSTER</i>			4. DATE OF DEATH Month <i>9</i> Day <i>11</i> Year <i>1958</i>		
5. SEX <i>Male</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> 3 DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <i>5/18/1899</i>	9. AGE (In years and month) <i>59</i>	IF UNDER 1 YEAR Months <i>0</i> Days <i>0</i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Farming</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Farming</i>	11. BIRTHPLACE (City and state or country) <i>Kansas</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>
13a. FATHER'S NAME <i>Wm. Luster</i>		13b. MOTHER'S MAIDEN NAME <i>Mary Wicker</i>		14. NAME OF HUSBAND OR WIFE <i>divorced</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war and dates of service) <i>no</i>		16. SOCIAL SECURITY NO. <i>unknown</i>	17. INFORMANT Address <i>Hospital records</i>		
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>Syphilitic Meningo-encephalitis</i>					INTERVAL BETWEEN ONSET AND DEATH <i>years</i>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) _____					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
DUE TO (c) _____					
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.) <i>none</i>		
20c. TIME OF INJURY Hour _____ Month, Day, Year _____ a.m. _____ p.m. _____			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.) <i>none</i>		
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>12/31/56</i> to <i>9/11/58</i> and last saw him alive on <i>9/11/58</i> Death occurred at <i>5:30 p.m.</i> on the date stated above; and to the best of my knowledge, from the causes stated.					
22a. SIGNATURE <i>George Esker M.D.</i> (Degree or title)			22b. ADDRESS <i>State Hospital #3 Nevada</i>		22c. DATE SIGNED <i>9/11/58</i>
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Removal</i>	23b. DATE <i>1958</i>	23c. NAME OF CEMETERY OR CREMATORY <i>State Anatomical Board</i>		23d. LOCATION (City, town, or county) (State) <i>St. Louis Missouri</i>	
24. FUNERAL DIRECTOR <i>Ferry Funeral Home</i>			ADDRESS <i>Nevada, Missouri</i>	25. DATE RECD. BY LOCAL REG. <i>9-12-1958</i>	26. REGISTRAR'S SIGNATURE <i>Anna E. Ferry</i>

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

Director, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed. All diseases in Part I must be causally related.

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 *L. Angelo Ferry*

Licensed Embalmer No. *7960*

P. O. Address *Nevada, N*

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.