

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

58-035482

STATE FILE NUMBER

FILED OCT 27 1958 Registration District No. 37 Primary Registration District No. 4049 Registrar's No. 39

300
1-57

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1. PLACE OF DEATH a. COUNTY BOONE		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MISSOURI b. COUNTY ANDRAN	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN CENTRALIA		c. CITY OR TOWN MEXICO	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION HULEN NURSING HOME		Length of stay in lb 50 Day	
3. NAME OF DECEASED (Type or print) SARAH		4. DATE OF DEATH Month Oct , Day 18 , Year 58	
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 Aug. 4, 1869	
9. AGE (In years last birthday) 89		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife	
11. BIRTH PLACE (City and state or country) Macon, Mo		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13a. FATHER'S NAME Unknown		13b. MOTHER'S MAIDEN NAME Unknown	
14. NAME OF HUSBAND OR WIFE ✓		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 Earl S. Pugh Mexico, 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) Encephalomalacia due to cerebral arteriosclerosis			INTERVAL BETWEEN ONSET AND DEATH months
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)			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 _____ a.m. _____ p.m.			
20d. INJURY OCCURRED WHILE AT <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 8/27/58 , to 10/16/58 and last saw her alive on 10/16/58 Death occurred at 12:45 a.m. m on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE Robert L. Ward M.D.		22b. ADDRESS Centralia, Mo.	
22c. DATE SIGNED 10/20/58			
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE Oct. 20, 58	
23c. NAME OF CEMETERY OR CREMATORY St. Brendan		23d. LOCATION (City, town, or county) (State) Mexico Mo	
24. FUNERAL DIRECTOR Pres. S. Houston		25. DATE RECD. BY LOCAL REG. Oct. 22-1958	
ADDRESS Mexico Mo		26. REGISTRAR'S SIGNATURE Maud M. Bride	

(Licensed Embalmer's Statement on Reverse Side)

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

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 *Earl E. Puck*

Licensed Embalmer No. *3189*
P. O. Address *Mexico MD*

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.