

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

58-035663
STATE FILE NUMBER

FILED NOV 7 1958 Registration District No. 44 Primary Registration District No. 5145 Registrar's No. 35

1. PLACE OF DEATH a. COUNTY Caldwell		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Mo. b. COUNTY Caldwell	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Breckenridge Twp.		c. CITY OR TOWN Breckenridge Twp.	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION none		d. STREET ADDRESS (If outside, give location)	
Length of stay in 1b 25 yrs.		Reside on Farm Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	

3. NAME OF DECEASED (Type or print) First ORA Middle LABINA Last MOORSHEAD			4. DATE OF DEATH 11/1/1958 Month Day Year		
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 7/26/1883	9. AGE (In years last birthday) 75 IF UNDER 1 YEAR: Months Days IF UNDER 24 HRS. 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 invalid	11. BIRTHPLACE (City and state or country) Caldwell Co., Mo.	12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME George F. Atkinson			14. MOTHER'S MAIDEN NAME Mary F. Colvin		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no (If yes, give war or dates of service) none		16. SOCIAL SECURITY NO.	17. INFORMANT Arthur Moorshead, Breckenridge, Mo. Address		

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Medullary fracture			INTERVAL BETWEEN ONSET AND DEATH 3 Days
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.		DUE TO (b) Cerebral thrombosis	
		DUE TO (c) Cerebral arteriosclerosis 332X	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Auricular fibrillation			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 Breckenridge Mo	COUNTY	STATE
21. I attended the deceased from 10/24/58 to 11/1/58 and last saw her alive on 10/1/58 Death occurred at 6:27 p.m. on the date stated above; and to the best of my knowledge, from the causes stated.				
22a. SIGNATURE (Degree or title) J. Woolbright Do²		22b. ADDRESS Breckenridge Mo		22c. DATE SIGNED 11/3/58

23a. BURIAL, CREMATION, REMOVAL (Specify) burial	23b. DATE 11/4/1958	23c. NAME OF CEMETERY OR CREMATORY Rose Hill cemetery	23d. LOCATION (City, town, or county) Breckenridge, Mo.
24. FUNERAL DIRECTOR Michael Funeral Home, Braymer, Mo.		25. DATE RECD. BY LOCAL REG. 11-5-1958	26. REGISTRAR'S SIGNATURE Mrs. Ruth Ann Jurgart

(Licensed Embalmer's Statement on Reverse Side)

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

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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 _____
Leub. Michael

Licensed Embalmer No. *43*

P. O. Address *Brazoria*

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.