

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

58-037526

STATE FILE NUMBER

*Dele.*

Registration District No. 316 Primary Registration District No. 3060 Registrar's No. 389

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|--|--|---|---|
| 1. PLACE OF DEATH<br>a. COUNTY <b>ST FRANCOIS</b>                                      |  | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before<br>a. STATE <b>MISSOURI</b> b. COUNTY <b>ST FRANCOIS</b> |   |
| b. CITY (If outside corporate limits, give TOWNSHIP only)<br>OR TOWN <b>FARMINGTON</b> | Inside Limits<br>Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> | c. CITY OR TOWN <b>FARMINGTON 09410</b>   | Inside Limits<br>Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>  |
| c. FULL NAME OF (If NOT in hospital, give location)<br>HOSPITAL OR INSTITUTION         | Length of stay in 1b   | d. STREET ADDRESS (If outside, give location)<br><b>609 E COLLEGE</b>   | Reside on Farm<br>Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> |

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| 3. NAME OF DECEASED (Type or print)<br>First <b>MILDRED</b> Middle <b>HIGHLEY</b> Last |  |  | 4. DATE OF DEATH<br>Month <b>Oct</b> Day <b>20</b> Year <b>1958</b> |  |  |
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|                      |                               |   |  |  |                               |                                |
|----------------------|-------------------------------|---|--|--|-------------------------------|--------------------------------|
| 5. SEX <b>FEMALE</b> | 6. COLOR OR RACE <b>WHITE</b> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> 2 DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><b>Aug 15 1878</b> | 9. AGE (In years 180 (thday))<br><b>80</b> | F UNDER 1 YEAR<br>Months Days | IF UNDER 24 HRS.<br>Hours Min. |
|----------------------|-------------------------------|---|--|--|-------------------------------|--------------------------------|

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| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>housewife</b> | 10b. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (City and state or country)<br><b>CASTALIA OHIO</b> | 12. CITIZEN OF WHAT COUNTRY?<br><b>USA</b> |
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|---|--|---|
| 13a. FATHER'S NAME<br><b>THOMAS PERRY</b> | 13b. MOTHER'S NAME<br><b>JULIA RORHACKER</b> | 14. NAME OF HUSBAND OR WIFE<br><b>MAURICE HIGHLEY</b> |
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|---|-------------------------|---|
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)<br><b>No</b> | 16. SOCIAL SECURITY NO. | 17. INFORMANT<br>Address<br><b>MRS. ROBERT SCHNEIDER FARMINGTON</b> |
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| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY<br>IMMEDIATE CAUSE (a) <b>Cerebral Hemorrhage</b> |  | INTERVAL BETWEEN ONSET AND DEATH<br><b>3 days</b>   |
| Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.  | DUE TO (b) <b>Hypertensive Cardio-Vascular Disease</b> |   |
|   | DUE TO (c) <b>Disease</b>                              |   |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)<br><b>443 X</b>         |  | 19. WAS AUTOPSY PERFORMED?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |

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| 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.) |
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| 20c. TIME OF INJURY<br>Hour Month, Day, Year<br>a.m.<br>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<br>COUNTY STATE |
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| 21. I attended the deceased from <b>1-29-55</b> to <b>10-20-58</b> and last saw her alive on <b>10-19-58</b><br>Death occurred at <b>3:00 A</b> m on the date stated above; and to the best of my knowledge, from the causes stated. |
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|   |                                      |                                     |
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| 22a. SIGNATURE (Degree or title)<br><b>C. E. Carleton, M.D.</b> | 22b. ADDRESS<br><b>Farmington Mo</b> | 22c. DATE SIGNED<br><b>10-21-58</b> |
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|  |                                 |   |  |
|--|---------------------------------|---|--|
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>BURIAL</b> | 23b. DATE<br><b>Oct 22 1958</b> | 23c. NAME OF CEMETERY OR CREMATORY<br><b>ST FRANCOIS MEMORIAL</b> | 23d. LOCATION (City, town, or county) (State)<br><b>DESLOGE MO</b> |
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| 24. FUNERAL DIRECTOR<br><b>COZEAN FARMINGTON MISSOURI</b> | 25. DATE RECD. BY LOCAL REG.<br><b>Oct. 23, 1958</b> | 26. REGISTRAR'S SIGNATURE<br><b>Esther Kudloff</b> |
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(Licensed Embalmer's Statement on Reverse Side)

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.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

S. 300  
1-57

89  
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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 *Ch Coyan* .....

Licensed Embalmer No. *4089* .....

P. O. Address *Temple* .....

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.