

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

58-040649

STATE FILE NUMBER

FILED DEC 15 1958

Registration District No. 184

Primary Registration District No. 3038

Registrar's No. 139

S. 300 4
1-57

All diseases in Part I must be causally related.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

1. PLACE OF DEATH a. COUNTY <u>Linn</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Linn</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Brookfield</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <u>Brookfield</u> 05820
c. FULL NAME OF (IF NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>Dreamer's Rest Home</u>		Length of stay in 1b <u>3 years</u>	d. STREET ADDRESS (If outside, give location) <u>121 North Penn</u>
3. NAME OF DECEASED (Type or print) First <u>Lillian</u> Middle <u>Maud</u> Last <u>Sheen</u>			4. DATE OF DEATH Month <u>Dec.</u> Day <u>6</u> Year <u>1958</u>
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Feb. 7, 1885</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Homemaker</u>	9. AGE (In years last birthday) <u>73</u> IF UNDER 1 YEAR: Months <u>9</u> Days <u>30</u> IF UNDER 24 HRS. Hours <u></u> Min. <u></u>
11. BIRTHPLACE (City and state or country) <u>Chariton Co., Missouri</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13a. FATHER'S NAME <u>John Marion Campbell</u>		13b. MOTHER'S MAIDEN NAME <u>Elizabeth Ann Clark</u>	
14. NAME OF HUSBAND OR WIFE <u>Albert Sheen (deceased)</u>		17. INFORMANT <u>Mrs. Betty Fawcett</u> Address <u>Brookfield, Mo.</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>no</u>		16. SOCIAL SECURITY NO. <u>None</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Hemorrhage</u>			INTERVAL BETWEEN ONSET AND DEATH <u>2 months.</u>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <u>Hypertension</u>			<u>30 Years.</u>
DUE TO (c) <u>Arteriosclerosis</u>			<u>35 years.</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>Thrombosis of the popliteal artery left leg.</u>			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.) <u>331X</u>	
20c. TIME OF INJURY Hour <u></u> Month, Day, Year <u></u> a.m. <u></u> p.m. <u></u>			
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.) <u></u>	
20f. CITY, TOWN, OR LOCATION <u></u>		COUNTY <u></u> STATE <u></u>	
21. I attended the deceased from <u>1951</u> to <u>Dec. 6, 1958</u> and last saw her/him alive on <u>Dec. 5, 1958</u> Death occurred at <u>3:15</u> p.m. on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE <u>R. E. Ryals</u> (Degree or title) <u>D.O.</u>		22b. ADDRESS <u>211 Linn Brookfield, Missouri</u>	
22c. DATE SIGNED <u>12-8-58</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE <u>Dec. 9, 1958</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>St. Michael Cemetery</u>		23d. LOCATION (City, town, or county) (State) <u>Brookfield, Missouri</u>	
24. FUNERAL DIRECTOR <u>Hill Funeral Home, Brookfield, Mo.</u>		25. DATE RECD. BY LOCAL REG. <u>12-9-58</u>	
26. REGISTRAR'S SIGNATURE <u>Katharine Johnson</u>			

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 *Gerald F. Wade*

Licensed Embalmer No. *4172*

P. O. Address *Bismarck*

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.