

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

58-040770
STATE FILE NUMBER

FILED NOV 21 1958 Registration District No. 2-1-2 Primary Registration District No. 3044 Registrar's No. 57

S. 300
1-57

1. PLACE OF DEATH a. COUNTY <u>MILLER</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Miller</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>ELDON</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <u>ELDON</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>EAST-NORTH-ST</u>		Length of stay in lb <u>14 mo</u>	d. STREET ADDRESS (If outside, give location) <u>066 EAST-NORTH-ST</u> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print) First Middle Last <u>THOMAS-Lewis-IZARD</u>			4. DATE OF DEATH Month Day Year <u>Nov-8-1958</u>		
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> / DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>26 July-1900</u>	9. AGE (In years last birthday) <u>58</u>	F UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Superintendent-</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Sheet-Metal</u>	11. BIRTHPLACE (City and state or country) <u>KANSAS-City-Mo</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>
13a. FATHER'S NAME <u>Thomas-L-IZARD</u>		13b. MOTHER'S MAIDEN NAME <u>Georgia-FLORANCE</u>		14. NAME OF HUSBAND OR WIFE <u>MABLE-STARRS-IZARD</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>	17. INFORMANT Address <u>MABLE-IZARD ELDON-MO</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>Decompensated Cor Pulmonale</u> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <u>Multiple Coronary Infarcts, old and recent</u> DUE TO (c) <u>Arteriosclerosis</u>		INTERVAL BETWEEN ONSET AND DEATH <u>4201</u>
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 Month, Day, Year 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
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21. I attended the deceased from Oct 16, 1958 to Nov 8, 1958 and last saw him alive on Oct 31, 1958
Death occurred at 5:30 a.m. on the date stated above; and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) <u>Robert M. Kays</u>	22b. ADDRESS <u>Eldon Mo</u>	22c. DATE SIGNED <u>11-8-58</u>
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23a. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE <u>11 Nov-1958</u>	23c. NAME OF CEMETERY OR CREMATORY <u>GREEN-LAWN</u>	23d. LOCATION (City, town, or county) (State) <u>KANSAS-City-Mo</u>
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24. FUNERAL DIRECTOR ADDRESS <u>Keith M. Kays ELDON-MO</u>	25. DATE RECD. BY LOCAL REG. <u>Nov. 8 '58</u>	26. REGISTRAR'S SIGNATURE <u>Alfred W. Wall</u>
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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

DEC 1 1958

NOV 21 1958

Miller County
Health Department

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 *Keith M. Faye*

Licensed Embalmer No. *3998*

P. O. Address *Eldon Mo.*

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.