Health, Welfare Public Service

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THE DIVISION OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

58-043023
STATE FILE NUMBER

FILED NOV 24 1958 Registration District No. 381 Primary Registration District No. 4515 Registrar's No. 117

1. PLACE OF DEATH
a. COUNTY: Sullivan
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN: Milan — Inside Limits: Yes ☑ No ☐
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION: Sull. Co. M. Hosp't — Length of stay in Ib: 6 mo

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Mo b. COUNTY: Sullivan
c. CITY OR TOWN: Milan 1050 0 — Inside Limits: Yes ☑ No ☐
d. STREET ADDRESS (If outside, give location) — Reside on Farm: Yes ☐ No ☑

3. NAME OF DECEASED (Type or print): First: Ada Middle: Belle Last: McAlister

4. DATE OF DEATH: Month 11 Day 13 Year 1958

5. SEX: Fem 1

6. COLOR OR RACE: W

7. MARRIED ☐ **NEVER MARRIED** ☐ **WIDOWED** ☑ 2 **DIVORCED** ☐

8. DATE OF BIRTH: 2-26-1875

9. AGE (In years last birthday): 83 — IF UNDER 1 YEAR: Months 8 Days 17 — IF UNDER 24 HRS.: Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): at home

10b. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (City and state or country): Milan - Mo 0

12. CITIZEN OF WHAT COUNTRY?: U.S.

13a. FATHER'S NAME: John Weaver

13b. MOTHER'S MAIDEN NAME: Lydia Montgomery

14. NAME OF HUSBAND OR WIFE: Harvey N. McAlister (dead)

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.: —

17. INFORMANT: Margorie Leslie — Address: Milan - Mo

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

All diseases in Part I must be causally related.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Cerebral Vascular Failure — INTERVAL BETWEEN ONSET AND DEATH: 2 mo
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.
DUE TO (b): Diabetes Mellitus — 3 yr.
DUE TO (c):
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a): 260X

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒ 0

20a. ACCIDENT ☐ **SUICIDE** ☐ **HOMICIDE** ☐

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. Month, Day, Year

20d. INJURY OCCURRED WHILE AT WORK ☐ **NOT WHILE AT WORK** ☐

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 July 1955 to Nov 1958 and last saw her alive on Nov 13 1958
Death occurred at 8:30 pm on the date stated above; and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title): Joseph S. Mignerey M.D.

22b. ADDRESS: Milan Mo

22c. DATE SIGNED: 11/14/58

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE: 11-15-58

23c. NAME OF CEMETERY OR CREMATORY: Oakwood Cem

23d. LOCATION (City, town, or county): Milan (State): Mo.

24. FUNERAL DIRECTOR: Schoene & Dwight Schoene — ADDRESS: Milan Mo

25. DATE RECD. BY LOCAL REG.: 11-15-58

26. REGISTRAR'S SIGNATURE: Mrs. M. W. Beckett

(Licensed Embalmer's Statement on Reverse Side)

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 Dwight Schoene

Licensed Embalmer No. 2667

P. O. Address Melan - M

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.