

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

58-043092

STATE FILE NUMBER

FILED DEC 5 1958 Registration District No. 366 Primary Registration District No. 4536 Registrar's No. 89

S. 300
1-57

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

1. PLACE OF DEATH a. COUNTY <i>Washington</i>				2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE <i>Missouri</i> COUNTY <i>Washington</i>					
b. CITY OR TOWN <i>Peters</i>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		c. CITY OR TOWN <i>Peters</i> 1100		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>			
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <i>904 Cresswell 4 yrs.</i>			Length of stay in 1b		d. STREET ADDRESS (If inside, give location) <i>904 Cresswell</i>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First <i>Lucy</i> Middle <i>Valner</i> Last <i>Valner</i>				4. DATE OF DEATH Month <i>Dec.</i> Day <i>1</i> Year <i>1958</i>					
5. SEX <i>Female</i>		6. COLOR OR RACE <i>White</i>		MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <i>May 15 1882</i>			
9. AGE (In years, last birthday) <i>76</i>		IF UNDER 1 YEAR Months <i>6</i> Days <i>76</i>		IF UNDER 24 HRS. Hours <i></i> Min. <i></i>					
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>House work</i>			10b. KIND OF BUSINESS OR INDUSTRY <i></i>		11. BIRTH PLACE (City and state or country) <i>Reynolds Co. Mo.</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>		
13a. FATHER'S NAME <i>John Mann</i>			13b. MOTHER'S MAIDEN NAME <i>Frances Dunn</i>			14. NAME OF HUSBAND OR WIFE <i>decd Valner</i>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <i>No</i>			16. SOCIAL SECURITY NO. <i></i>		17. INFORMANT Name <i>Hersbert Valner</i> Address <i>Peters Mo.</i>				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Medullary Failure (Embolic Encephalomalacia)</i>							INTERVAL BETWEEN ONSET AND DEATH		
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <i>Cardiac mural Thrombus formation + thrombotic myocardial infarction</i>									
DUE TO (c) <i>Arteriosclerosis</i>									
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <i>Severe Hypertension</i>							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.) <i>4201</i>						
20c. TIME OF INJURY Hour <i></i> Month <i></i> Day <i></i> Year <i></i> a.m. <i></i> p.m. <i></i>									
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	
21. I attended the deceased from <i>1955</i> to <i>12/1/58</i> and last saw her alive on <i>12/1/58</i> Death occurred at <i>11:30 P.M.</i> on the date stated above; and to the best of my knowledge, from the causes stated.									
22a. SIGNATURE <i>Bergm. Spoor DO.</i> (Degree or title)				22b. ADDRESS <i>221 E. High St. Mo.</i>			22c. DATE SIGNED <i>12/2/58</i>		
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE <i>12-4-58</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Cats Cemetery</i>		23d. LOCATION (City, town, or county) <i>Reynolds Co. Mo.</i>			
24. FUNERAL DIRECTOR <i>Mrs. Lillian Sparks Peters Mo.</i> ADDRESS <i></i>				25. DATE RECD. BY LOCAL REG. <i>12/2/58</i>		26. REGISTRAR'S SIGNATURE <i>Hersbert Valner</i>			

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WASH. COUNTY HEALTH DEPT.

File No: _____

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 *Murphy L. ...*

Licensed Embalmer No. *4236*

P. O. Address *Flat ...*

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.