

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

58-043709

STATE FILE NUMBER

FILED DEC 17 1958 Registration District No. 114 Primary Registration District No. 4186 5422 Registrar's No. 44

1. PLACE OF DEATH a. COUNTY FRANKLIN		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MISSOURI b. COUNTY FRANKLIN	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN SULLIVAN		Inside Limits Yes <input checked="" type="checkbox"/> No <input checked="" type="checkbox"/>	c. CITY OR TOWN SULLIVAN 0360
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION R. R. #2		Length of stay in 1b 7Mo	d. STREET ADDRESS (If outside, give location) R. R. #2

3. NAME OF DECEASED (Type or print) First Middle Last LAURA - TANNER			4. DATE OF DEATH Month Day Year 12-8-1958		
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5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 4-29-9	9. AGE (In years or birthday) 88	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife	10b. KIND OF BUSINESS OR INDUSTRY Home	11. BIRTHPLACE (City and state or country) KENTUCKY	12. CITIZEN OF WHAT COUNTRY? U.S.A.
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13a. FATHER'S NAME HENRY SPICER	13b. MOTHER'S MAIDEN NAME UNKNOWN	14. NAME OF HUSBAND OR WIFE Joe (dec)
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15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give way or dates of service) No	16. SOCIAL SECURITY NO. None	17. INFORMANT Sadie MURCHINSON, ST. LOUIS, MO	Address
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18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) PNEUMONIA, BRONCHIAL		INTERVAL BETWEEN ONSET AND DEATH 4 DAYS
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) INFIRMITIES OF OLD AGE	
	DUE TO (c) _____	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) 491X		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.)
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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 Death occurred at MAY 20-58 to DEC. 8-58 and last saw her alive on DEC. 7-1958 at 1140 P m on the date stated above; and to the best of my knowledge, from the causes stated.		
22a. SIGNATURE (Degree or title) Robert M. [Signature]	22b. ADDRESS SULLIVAN, MO	22c. DATE SIGNED Dec 8-1958

23a. BURIAL, CREMATION, REMOVAL (Specify) Removal	23b. DATE 12-11-58	23c. NAME OF CEMETERY OR CREMATORY MT. HOPE	23d. LOCATION (City, town, or county) (State) ST. LOUIS, MO.
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24. FUNERAL DIRECTOR MSLAUGHLIN F.H. ST. LOUIS, MO.	25. DATE RECD. BY LOCAL REG. 12-10-58	26. REGISTRAR'S SIGNATURE Thomas A. Humphrey
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USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE
MEDICAL CERTIFICATION

All diseases in Part I must be causally related.

300
1-57

60
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1961 & NBC

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 *James R. Chapman*

Licensed Embalmer No. *4550*

P. O. Address *St. Louis, 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.