

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

58-045343

STATE FILE NUMBER

FILED DEC 23 1958

Registration District No. 316 Primary Registration District No. 6075 Registrar's No. 452

1. PLACE OF DEATH a. COUNTY <u>St. Francois</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>St. Francois</u>					
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>St. Francois Twp. Farmington-Rural</u>		Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>		c. CITY OR TOWN <u>Flat River</u> <u>0942</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>Thomas W. M. Home</u>			Length of stay in 1b		d. STREET ADDRESS (If outside, give location) <u>500 Jefferson</u>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) <u>Mrs. Adah May Presser</u>				4. DATE OF DEATH Month <u>Dec</u> Day <u>8</u> Year <u>1958</u>					
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White case</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>Jan. 6 - 1878</u>		9. AGE (In years last birthday) <u>80-11-2</u>	IF UNDER 1 YEAR Months _____ Days _____ Hours _____	IF UNDER 24 HRS. Min. _____	
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		11. BIRTHPLACE (City and state or country) <u>Jetsville Pennsylvania</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		
13. FATHER'S NAME <u>Mr. Alexander A. Smythe</u>				14. MOTHER'S MAIDEN NAME <u>Mary Pollock</u>					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yrs, give year or dates of service) <u>no</u>		16. SOCIAL SECURITY NO. <u>none</u>		17. INFORMANT Address <u>Mrs. Dorothy Gentle - Flat River, 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>Hypostatic Pneumonia</u>							INTERVAL BETWEEN ONSET AND DEATH <u>2 1/2 hrs</u>		
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.		DUE TO (b) <u>Myocarditis</u>					1 month		
		DUE TO (c) <u>Arteriosclerosis</u>					Unknown		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>4221</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.)						
20c. TIME OF INJURY Hour _____ 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	
21. I attended the deceased from <u>Nov 10 1958</u> to <u>Dec 8, 1958</u> and last saw ^{her} _{him} alive on <u>Dec 7, 1958</u> Death occurred at <u>8:15 am</u> m on the date stated above; and to the best of my knowledge, from the causes stated.									
22a. SIGNATURE (Degree or title) <u>L. M. Stanley MD</u>				22b. ADDRESS <u>Farmington Mo</u>			22c. DATE SIGNED <u>12/13/58</u>		
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE	23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City, town, or county)		STATE		
<u>Buried</u>		<u>Dec. 10 - 1958</u>	<u>St. Francois Memorial Park</u>		<u>Route No. 1, Bonne Terre Mo.</u>				
24. FUNERAL DIRECTOR <u>Alvin W. Hood - 303 Crane St. Flat River, Mo.</u>			ADDRESS		25. DATE RECD. BY LOCAL REG. <u>Dec. 13, 1958</u>		26. REGISTRAR'S SIGNATURE <u>Ethel Redloff</u>		

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

Health, Welfare, Public Service
300
1-56
All diseases in Part I must be causally related. Coroner cannot certify to a death due to natural causes. No symptoms will be listed. All diseases in Part I must be causally related. Coroner cannot certify to a death due to natural causes.

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 *Alvin W. Hood*.....

Licensed Embalmer No. *27*
303 Crane St
P. O. Address *Flat River*

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. 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.