

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

58-046869

STATE FILE NUMBER

FILED DEC 29 1958 Registration District No. 324 Primary Registration District No. 1417 Registrar's No. 217

1. PLACE OF DEATH a. COUNTY <i>Saline</i>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Missouri</i> b. COUNTY <i>Saline</i>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <i>Malta Bend</i>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <i>Malta Bend</i> <sup>217</sup> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION _____		Length of stay in 1b <i>14 yrs</i>	d. STREET ADDRESS (If outside, give location) _____ Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) <i>MABEL</i> <sup>First</sup> <i>MINERVA</i> <sup>Middle</sup> <i>MURPHY</i> <sup>Last</sup>			4. DATE OF DEATH <i>Dec. 22, 1958</i>
5. SEX <i>Female</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>Nov. 19, 1883</i>
9. AGE (In years last birthday) <i>75</i>		10. IF UNDER 1 YEAR Months _____ Days _____	11. IF UNDER 24 HRS. Hours _____ Min. _____
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Own Home</i>	11. BIRTHPLACE (City and state or country) <i>Carroll County, Mo</i>
12. CITIZEN OF WHAT COUNTRY? <i>U. S. A.</i>		13. FATHER'S NAME <i>Charles A Meier</i>	
14. MOTHER'S MAIDEN NAME <i>Loretta Page</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. _____		17. INFORMANT <i>David E Murphy</i> Address <i>Malta Bend, 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>Bronchial Pneumonia</i> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <i>Parkinson's Disease</i> DUE TO (c) <i>Senility</i>			INTERVAL BETWEEN ONSET AND DEATH <i>3 days</i> <i>3 yrs</i> <i>8 yrs</i>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>350X</i>			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/> 0
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 WORK <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>1950</i> to <i>12-22-58</i> and last saw her alive on <i>Dec 22-58</i> Death occurred at <i>6:45 p. m.</i> on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE <i>Edward Waverly</i> (Doctor or nurse)		22b. ADDRESS _____	22c. DATE SIGNED _____
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>	23b. DATE <i>12-27-1958</i>	23c. NAME OF CEMETERY OR CREMATORY <i>Oak Hill</i>	23d. LOCATION (City, town, or county) (State) <i>Carrollton Mo.</i>
24. FUNERAL DIRECTOR <i>Harry Herzberger</i> ADDRESS <i>Marshall, Mo</i>		25. DATE RECD. BY LOCAL REG. <i>12-26-58</i>	26. REGISTRAR'S SIGNATURE <i>Cecil G. Reed</i>

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

W. E. A. JONES

Health, Welfare, Public Services

300 1-56

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. 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 *Harry Hershberger*

Licensed Embalmer No. *43*

P. O. Address *Marsha*

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.