

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

58-047325
STATE FILE NUMBER

FILED MAR 11 1959 Registration District No. 301 Primary Registration District No. 6042 Registrar's No. 15

1. PLACE OF DEATH a. COUNTY RIPLEY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MISSOURI b. COUNTY RIPLEY	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Oxly		Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	c. CITY OR TOWN Oxly 0910
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION AT HOME		Length of stay in 1b YEARS	d. STREET ADDRESS (If outside, give location) GEN. DELIVERY
3. NAME OF DECEASED (Type or print) First Middle Last DAISY DEAN DABBS			4. DATE OF DEATH Month Day Year DEC. 28-1958
5. SEX Female	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> 2 DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Nov. 2-1881
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY AT HOME	9. AGE (In years last birthday) 77
11. BIRTHPLACE (City and state or country) ILLINOIS		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13a. FATHER'S NAME George GROSSAGE		13b. MOTHER'S MAIDEN NAME NANCY MITCHELL	14. NAME OF HUSBAND OR WIFE BRICE DABBS
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. NONE	17. INFORMANT MRS. TROY ORMSBY - Oxly - Mo.
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 Hemorrhage			INTERVAL BETWEEN ONSET AND DEATH 20 days
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. } DUE TO (b) Cerebral Arteriosclerosis			YEARS
DUE TO (c) _____			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) 331X			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> 2
20a. ACCIDENT SUICIDE HOMICIDE <input type="checkbox"/> <input type="checkbox"/> <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. Month, Day, Year			
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 Dec. 8, 1958 , to Dec. 28, 1958 and last saw her alive on Dec. 19, 1958 Death occurred at 5:50 A.M. on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE J. L. Smith (Degree or title) DO. 2		22b. ADDRESS Naylor, Mo.	22c. DATE SIGNED 1-10-59
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	23b. DATE 12-30-58	23c. NAME OF CEMETERY OR CREMATORY ANTIOCH Cemetery	23d. LOCATION (City, town, or county) (State) Oxly - Mo.
24. FUNERAL DIRECTOR Edwards Parrent ADDRESS NAYLOR, Mo.		25. DATE RECD. BY LOCAL REG. Mar. 5-59	26. REGISTRAR'S SIGNATURE Flava Broz

(Licensed Embalmer's Statement on Reverse Side)

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

All diseases in Part I must be causally related.

300
1-57

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 *Gene Harrent*

Licensed Embalmer No. *4809*
P. O. Address *Naylor, Va*

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.