

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

59-000083  
STATE FILE NUMBER

FILED JAN 16 1959 Registration District No. 10 Primary Registration District No. 3002 Registrar's No. 11

1. PLACE OF DEATH a. COUNTY <b>AUDRAIN</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MO.</b> b. COUNTY <b>MONROE</b>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>MEXICO</b> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		c. CITY OR TOWN <b>GROSS 6698</b> Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>AUDRAIN COUNTY HOSPITAL</b> Length of stay in 1b <b>1/2 Day</b>		d. STREET ADDRESS <b>5-MI. E. OF PARIS (If outside, give location)</b> <b>PARIS R.F.D.</b> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>ANNIE</b> Middle <b>MATILDA</b> Last <b>JENNINGS</b>		4. DATE OF DEATH Month <b>JAN.</b> Day <b>6</b> Year <b>1959</b>	
5. SEX <b>F</b>	6. COLOR OR RACE <b>W</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>AUG. 20, 1879</b>
9a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOUSEWIFE</b>		9b. KIND OF BUSINESS OR INDUSTRY <b>AT HOME</b>	9c. AGE (In years last birthday) <b>79</b> IF UNDER 1 YEAR: Months <b>4</b> Days <b>16</b> Hours <b>-</b> Min. <b>-</b>
10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOUSEWIFE</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>AT HOME</b>	10c. BIRTHPLACE (City and state or country) <b>NEW FLORENCE, MO.</b>
11. BIRTHPLACE (City and state or country) <b>NEW FLORENCE, MO.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>A. D. HARRISON</b>		14. MOTHER'S MAIDEN NAME <b>MARY K. ARCHER</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b>		16. SOCIAL SECURITY NO. <b>NONE</b>	17. INFORMANT <b>MRS LEE JOHNSON</b> Address <b>1115 S CALHOUN MEXICO, MO.</b>
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Myocardial Infarction</b>			INTERVAL BETWEEN ONSET AND DEATH <b>1 hr</b>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <b>Pulmonary Edema</b>			<b>24 hrs</b>
DUE TO (c) <b>Congestive Heart Failure</b>			<b>?</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <b>H2O1</b>			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> <b>2</b>
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 _____ 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 <b>Mexico Audrain Mo.</b>	
21. I attended the deceased from <b>1-5-59</b> to <b>1-6-59</b> and last saw her/him alive on <b>1-6-59</b> Death occurred at <b>11:30 A</b> m on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree or title) <b>Laurance K. Apple, M.D.</b>		22b. ADDRESS <b>Mexico Mo</b>	
22c. DATE SIGNED <b>1-6-59</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>	23b. DATE <b>JAN 8, 1959</b>	23c. NAME OF CEMETERY OR CREMATORY <b>ELM WOOD CEM</b>	23d. LOCATION (City, town, or county) (State) <b>MEXICO, MO.</b>
24. FUNERAL DIRECTOR ADDRESS <b>SPEED &amp; BLAKEY PARIS, MISSOURI</b>		25. DATE RECD. BY LOCAL REG. <b>Jan 6 1959</b>	26. REGISTRAR'S SIGNATURE <b>Blanche Neely</b>

diseases in Part I must be causally related. Coroner cannot certify to a death due to natural causes.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE  
LAWRENCE K. APPLE, M.D.

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STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was e  
by me, or by ..... Student Embalmer No.....  
working under my personal supervision..

Student.....  
Signature of Student Embalmer

Signed..... *E. H. Agnew* .....

Licensed Embalmer No. *40*

P. O. Address *PARIS, MISSOURI* .....

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.