

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

59-000646

STATE FILE NUMBER

JAN 13 1959 Registration District No. 73 Primary Registration District No. 5291 Registrar's No. 10

300
1-57

1. PLACE OF DEATH a. COUNTY Clay		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY Buchanan	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Liberty Twp.		Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	c. CITY OR TOWN Agency 0110 Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION IOOF Hospital		Length of stay in lb months	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) First Pearl Middle Last Puett			4. DATE OF DEATH Month Jan. Day 5, Year 1959		
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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 Nov. 22, 1881	9. AGE (In years last birthday) 77	IF UNDER 1 YEAR Months Days Hours Min.	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) unknown		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and state or country) Missouri	12. CITIZEN OF WHAT COUNTRY? USA
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13a. FATHER'S NAME G. D. Sherwood		13b. MOTHER'S MAIDEN NAME Elizabeth Defields		14. NAME OF HUSBAND OR WIFE unknown	
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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. unknown	17. INFORMANT Address IOOF Hospital Records Liberty Mo		
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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) Heart Block				INTERVAL BETWEEN ONSET AND DEATH ?
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.		DUE TO (b) Arteriosclerosis		
		DUE TO (c)		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) 4330				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 Dec 25 59 and last saw her alive on Jan 4 59 Death occurred at 9 A m on the date stated above; and to the best of my knowledge, from the causes stated.		
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22a. SIGNATURE (Degree or title) Wm A Gaddison		22b. ADDRESS Liberty Mo		22c. DATE SIGNED 1/5/59	
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23a. BURIAL, CREMATION, REMOVAL (Specify) Removal		23b. DATE Jan. 5, 1959		23c. NAME OF CEMETERY OR CREMATORY IOOF Cemetery		23d. LOCATION (City, town, or county) (State) St. Joseph, Missouri	
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24. FUNERAL DIRECTOR ADDRESS Tyler-Pasley Funeral Home		25. DATE RECD. BY LOCAL REG. 1-10-59		26. REGISTRAR'S SIGNATURE Walter Graham	
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Item 2b added by query of Funeral Director
 USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE 2-9-59
 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.

MEDICAL CERTIFICATION

FEB 24 1959

JAN 30 1959

FEB 3 1959



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 *John Pasley*

Licensed Embalmer No. *4308*
P. O. Address *Liberty*

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.