

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

59-006715
STATE FILE NUMBER

Health,
Welfare
Public
Service

FILED MAR 5 1959 Registration District No. 294 Primary Registration District No. 3056 Registrar's No. 43

300
1-57

1. PLACE OF DEATH a. COUNTY <u>Randolph</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Boone</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Moberly</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <u>Sturgers</u> 0100 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>Community Memorial Hosp.</u>		Length of stay in lb <u>3 1/2 hours</u>	d. STREET ADDRESS (If outside, give location) <u>—</u> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print) First <u>Mary</u> Middle <u>D.</u> Last <u>Smith</u>			4. DATE OF DEATH Month <u>Feb.</u> Day <u>21</u> Year <u>1959</u>		
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5. SEX <u>Female</u>	6. COLOR OR RACE <u>white</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. 2 - 1870</u>	9. AGE (In years last birthday) <u>89</u>	IF UNDER 1 YEAR Months <u>1</u> Days <u>19</u>	IF UNDER 24 HRS Hours <u>—</u> Min. <u>—</u>
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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 <u>Housewife</u>	11. BIRTHPLACE (City and state or country) <u>Andrain Co. Mo.</u>	12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>
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13a. FATHER'S NAME <u>Simon Winsett</u>	13b. MOTHER'S MAIDEN NAME <u>Amelia Crosswhite</u>	14. NAME OF HUSBAND OR WIFE <u>Deceased</u>
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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) <u>NO</u>	16. SOCIAL SECURITY NO. <u>NONE</u>	17. INFORMANT <u>M. E. Winsett, Sturgers, Mo.</u>
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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) <u>Uremia</u>		INTERVAL BETWEEN ONSET AND DEATH <u>2 hrs.</u>	
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) <u>Nephritis</u>		<u>3 1/2 hrs</u>
	DUE TO (c) <u>90% Burns to the Body</u>		<u>4 hrs.</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)		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 <u>—</u> Month, Day, Year a.m. <u>—</u> p.m. <u>—</u>	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 <u>—</u> STATE <u>—</u>
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21. I attended the deceased from <u>April 1958</u> to <u>Feb 21, 1959</u> and last saw her alive on <u>Feb 21, 1959</u> Death occurred at <u>12:50 A</u> 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) <u>Denny J. Stewart D.O.</u>	22b. ADDRESS <u>Sturgers, Mo</u>	22c. DATE SIGNED <u>2-23-59</u>
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23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE <u>2-23-1959</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Macedonia Cemetery</u>	23d. LOCATION (City, town, or county) (State) <u>Andrain Co. Mo.</u>
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24. FUNERAL DIRECTOR <u>Lawrence J. Ballou, Centralia, Mo.</u>	25. DATE RECD. BY LOCAL REG. <u>2/23/59</u>	26. REGISTRAR'S SIGNATURE <u>Paul H. Love</u>
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(Licensed Embalmer's Statement on Reverse Side)

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE
MEDICAL CERTIFICATION
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.

DEC 5 1962

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 *Paul J. Ballou*

Licensed Embalmer No. *4206*....
P. O. Address *Centradia, M*

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.