

Health,
Welfare
Public
Service

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

59-008320
STATE FILE NUMBER

FILED MAR 24 1959 Registration District No. 6 Primary Registration District No. 3001 Registrar's No. 5

300
1-57

1. PLACE OF DEATH a. COUNTY Audrain		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Illinois b. COUNTY Washington	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Vandalia,		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN Willisville
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION 501 N. Vine		Length of stay in lb 10 DAYS	d. STREET ADDRESS (If outside, give location) 8120 9
3. NAME OF DECEASED (Type or print) First Katherine Middle Last Soper		4. DATE OF DEATH Month March Day 17 Year 1959	
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 2-2-00
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY	9. AGE (In years at birthday) 59
11. BIRTHPLACE (City and state or country) Willisville, Ill.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13a. FATHER'S NAME Burl Soper		13b. MOTHER'S MAIDEN NAME Katherine Freeman	14. NAME OF HUSBAND OR WIFE ROBERT SOPER
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. 360-245815	17. INFORMANT Address Roy Gower Vandalia, 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) Coronary occlusion DUE TO (b) Generalized arteriosclerosis DUE TO (c) Arteriosclerotic heart disease degenerated PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) diabetes mellitus, med 2 weeks 426C			INTERVAL BETWEEN ONSET AND DEATH 1 month
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 <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 3/7/59 to 3/17/59 and last saw her alive on 3/1/59 Death occurred at 430 PM on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE Edward Soper MD (Degree or title)		22b. ADDRESS Vandalia Mo	22c. DATE SIGNED 3/18/59
23a. BURIAL (Specify)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION (City, town, or county) (State)
Burial	March 29-59	Cutler Cemetary	Cutler, Illinois

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

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.

FUNERAL DIRECTOR **William B Waters** ADDRESS **Vandalia, Mo.** 25. DATE RECD. BY LOCAL REG. **March 18 1959** 26. REGISTRAR'S SIGNATURE **Dollie Fugate**

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 *William P. Waters*
Licensed Embalmer No. *4169*
P. O. Address *Vandalia*

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.