

Health,
Welfare
Public
Service

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

59-008691

STATE FILE NUMBER

FILED APR 2 1959 Registration District No. 59 Primary Registration District No. 2227 Registrar's No. 60

1. PLACE OF DEATH a. COUNTY CASS		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MISSOURI b. COUNTY CASS	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN HARRISONVILLE		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN FREEMAN 0190 0
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION PLEASANT VIEW HOME		Length of stay in 1b 3 YRS.	d. STREET ADDRESS (If outside, give location) Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print) First Middle Last WINIFORD FLORENCE TRIBBY			4. DATE OF DEATH Month Day Year MARCH 21, 1959		
5. SEX F	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> 2 DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 8-11-1868	9. AGE (In years last birthday) 90	IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10b. KIND OF BUSINESS OR INDUSTRY HOME	11. BIRTHPLACE (City and state or country) BUCHANAN Co. Mo.	12. CITIZEN OF WHAT COUNTRY? U.S.A.	

13a. FATHER'S NAME JACKSON FRANKS		13b. MOTHER'S MAIDEN NAME ELIZA STANTON		14. NAME OF HUSBAND OR WIFE JOHN ADAM TRIBBY DECEASED	
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 Address MRS. CHARLES SIMMONS DREXEL, 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) Pulmonary Edema			INTERVAL BETWEEN ONSET AND DEATH. 2 days	
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) Cardiac Insufficiency			10 yrs
	DUE TO (c) Atherosclerosis 40.21			10 yrs
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.)		
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 Jan 1957 to Mar 21, 1959 and last saw her alive on Mar 21, 1959 . Death occurred at 10:15 p.m. on the date stated above; and to the best of my knowledge, from the causes stated.					

22a. SIGNATURE R. C. Groch MD		(Degree or title) 2	22b. ADDRESS Harrisonville Mo	22c. DATE SIGNED Mar 23, 1959
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23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	23b. DATE 3-25-59	23c. NAME OF CEMETERY OR CREMATORY FREEMAN CEMETERY	23d. LOCATION (City, town, or county) (State) FREEMAN CASS COUNTY Mo.
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24. FUNERAL DIRECTOR RUNYAN FUNERAL HOME	ADDRESS DREXEL, Mo	25. DATE RECD. BY LOCAL REG. 3-24-59	26. REGISTRAR'S SIGNATURE Mrs Ray Sebree
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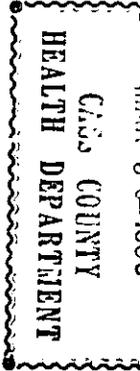
(Licensed Embalmer's Statement on Reverse Side)

300
1-57

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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.



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 *Walter B. Bergman*

Licensed Embalmer No. *3222*
P. O. Address *Paula Kanne*

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.