

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

59-008851

STATE FILE NUMBER

FILED APR 14 1959

Registration District No. 82

Primary Registration District No. 3017

Registrar's No. 51

300  
-57

1. PLACE OF DEATH a. COUNTY <i>Cooper</i>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Missouri</i> b. COUNTY <i>Cooper</i>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <i>Boonville</i>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <i>Bunceton</i> (27%) Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
c. FULL NAME OF DECEASED (If NOT in hospital give location) <i>St. Joseph Hosp</i>		Length of stay in hospital <i>2 weeks</i>	d. STREET ADDRESS (If outside, give location) <i>10 miles north of B.</i> Reside on Farm Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Middle Last <i>MARY - ANNA - SLY</i>			4. DATE OF DEATH Month Day Year <i>April 2, 1959</i>
5. SEX <i>F</i>	6. COLOR OR RACE <i>white</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>July 9, 1869</i>
9. AGE (In years, months, days) <i>89</i>		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>housewife</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>same</i>	11. BIRTHPLACE (City and state or country) <i>Pat Grove, Mo</i>
12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>		13a. FATHER'S NAME <i>Henry Schlathauer</i>	
13b. MOTHER'S MAIDEN NAME <i>Mary Catherine Kahra</i>		14. NAME OF HUSBAND OR WIFE <i>Ed Sly</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, unknown) (If yes, give year or dates of service) <i>No</i>		16. SOCIAL SECURITY NO. <i>466X</i>	17. INFORMANT <i>Kathylene Stegner</i> Address <i>Bunceton, Mo</i>
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>acute cor pulmonale</i>			INTERVAL BETWEEN ONSET AND DEATH <i>3-16-59</i>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <i>Pulmonary Embolism repeated</i>			1 week
DUE TO (c) <i>phlebotrombosis left leg</i>			
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"/> 2			
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 <i>3-16-59</i> to <i>4-2-59</i> and last saw her/him alive on <i>4-2-59</i> Death occurred at <i>3:55 P.M.</i> on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Type or print) <i>William A. Albr. MD</i>		22b. ADDRESS <i>329 Main Street, Boonville, Mo.</i>	22c. DATE SIGNED <i>4/6/59</i>
23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE <i>April 4, 1959</i>	23c. NAME OF CEMETERY OR CREMATORY <i>Pat Grove Ceme</i>	23d. LOCATION (City, town, or county) (State) <i>Pat Grove, Mo</i>
24. FUNERAL DIRECTOR <i>Hays - Lanter, Pat Grove, Mo</i>		25. DATE RECD. BY LOCAL REG. <i>4/6/59</i>	26. REGISTRAR'S SIGNATURE <i>D. Hooper</i>

(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 referring to diseases in Part I must be causally related.

AUG 28 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 *Robert L. Vanite*

Licensed Embalmer No. *4069*  
P. O. Address *Pilot Grove,*

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.