

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

59-010344  
STATE FILE NUMBER

FILED APR 9 1959 Registration District No. 272 Primary Registration District No. 4403 Registrar's No. 22

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| 1. PLACE OF DEATH<br>a. COUNTY <u>Fernand</u>                                      |  | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <u>Missouri</u> b. COUNTY <u>Fernand</u> |  |
| b. CITY (If outside corporate limits, give TOWNSHIP only)<br>OR TOWN <u>Steele</u> |  | Inside Limits<br>Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>   | c. CITY OR TOWN <u>Steele</u><br>Inside Limits<br>Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>  |
| c. FULL NAME OF (IF NOT in hospital, give location)<br>HOSPITAL OR INSTITUTION     |  | Length of stay in 1b   | d. STREET ADDRESS (If outside, give location)<br><u>078 So Walnut</u><br>Reside on Farm<br>Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> |

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|---|--------------------------------|---|--|--|---|
| 3. NAME OF DECEASED (Type or print)<br>First <u>Albe</u> Middle <u>Acoster</u> Last |                                |   | 4. DATE OF DEATH<br>Month <u>3</u> Day <u>4</u> Year <u>59</u> |  |   |
| 5. SEX<br><u>M</u>  | 6. COLOR OR RACE<br><u>Col</u> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><u>unknown Oct 62</u>                      |  | 9. AGE (In years, last birthday)<br>IF UNDER 1 YEAR<br>Months Days Hours Min. |

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| 10a. USUAL OCCUPATION (Of the kind of work done during most of working life, even if retired)<br><u>Laborer</u> | 10b. KIND OF BUSINESS OR INDUSTRY<br><u>Farm</u> | 11. BIRTHPLACE (City and state or country)<br><u>Crittenden Co Ark</u> | 12. CITIZEN OF WHAT COUNTRY?<br><u>US</u>          |
| 13a. FATHER'S NAME<br><u>Albe Acoster</u>   |  | 13b. MOTHER'S MAIDEN NAME<br><u>Wm Acoster</u>                         | 14. NAME OF HUSBAND OR WIFE<br><u>Mary Acoster</u> |

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|--|-------------------------|---|
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, last, or unknown) (If yes, give war or dates of service)<br><u>No</u> | 16. SOCIAL SECURITY NO. | 17. INFORMANT<br><u>Mary Acoster</u> Address <u>Steele Mo</u> |
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| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>acute Pulmonary Edema</u> |  | INTERVAL BETWEEN ONSET AND DEATH<br><u>Immediate</u>  |
| Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.   | DUE TO (b) <u>Congestive Heart Failure</u>       | <u>3-3 yrs</u>  |
|  | DUE TO (c) <u>Arteriosclerotic Heart Disease</u> | <u>2-3 yrs</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?<br>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<br>Hour 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 Fall, 1957 to 3-3-59 and last seen alive on 3-3-59.  
Death occurred at \_\_\_\_\_ m on the date stated above; and to the best of my knowledge, from the causes stated.

|   |                                    |                                    |
|---|------------------------------------|------------------------------------|
| 22a. SIGNATURE<br><u>Paul E. Holcomb M.D.</u> (Degree or title) | 22b. ADDRESS<br><u>Steele, Mo.</u> | 22c. DATE SIGNED<br><u>3/26/59</u> |
|---|------------------------------------|------------------------------------|

|   |                            |  |  |
|---|----------------------------|--|--|
| 23a. BURIAL, CREMATION, REMOVAL (Specify) | 23b. DATE<br><u>2-8-59</u> | 23c. NAME OF CEMETERY OR CREMATORY<br><u>Holly Grove</u> | 23d. LOCATION (City, town, or county) (State)<br><u>Steele, Mo</u> |
|---|----------------------------|--|--|

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| 24. FUNERAL DIRECTOR<br><u>Samuel Howard</u> ADDRESS <u>Steele, Mo</u> | 25. DATE RECD. BY LOCAL REG.<br><u>4-4-59</u> | 26. REGISTRAR'S SIGNATURE<br><u>[Signature]</u> |
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(Licensed Embalmer's Statement on Reverse Side)

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

All diseases in Part I must be causally related.

VS 1980

YS JUN 7 1980

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 *Noel C. Dean* .....

Licensed Embalmer No. *3941* .....

P. O. Address *Caruthers* .....

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.