

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

59-010487  
STATE FILE NUMBER

FILED MAR 18 1959

Registration District No. 290 Primary Registration District No. \_\_\_\_\_ Registrar's No. 22

1. PLACE OF DEATH a. COUNTY <b>Pulaski Co</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Missouri</b> b. COUNTY <b>Pulaski</b>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>Waynesville, Mo.</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <b>Devils Elbow, Mo.</b> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR Way. Gen. Hosp. INSTITUTION		Length of stay in 1b <b>2 yrs.</b>	d. STREET ADDRESS (If outside, give location) <b>None.</b> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <b>Jennie</b> Middle <b>Charlotte.</b> Last <b>Larson.</b>			4. DATE OF DEATH Month <b>March</b> Day <b>9,</b> Year <b>1959</b>
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White.</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>July 17, 1883</b>
9. AGE (In years last birthday) <b>75</b>		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) <b>Bookkeeper.</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>*****</b>	11. BIRTHPLACE (City and state or country) <b>Illinois</b>
12. CITIZEN OF WHAT COUNTRY? <b>USA</b>		13a. FATHER'S NAME <b>Johann. Larson.</b>	
13b. MOTHER'S MAIDEN NAME <b>Augusta C. Unknown.</b>		14. NAME OF HUSBAND OR WIFE <b>None.</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>None.</b>	17. INFORMANT Address <b>Mrs. Alice Mottz Devils Elbow, Mo</b>
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral Hemorrhage</b> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. } DUE TO (b) <b>Arteriosclerosis</b> DUE TO (c) <b>Hypertension</b>			INTERVAL BETWEEN ONSET AND DEATH <b>10 days</b>
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"/> <b>2</b>
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 <b>2-6-1957</b> , to <b>3-9-59</b> and last saw her alive on <b>3-8-59</b> Death occurred at <b>1:01</b> P. m on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree or title) <b>R. O. Mottz D.O.</b>		22b. ADDRESS <b>Waynesville, Mo.</b>	22c. DATE SIGNED <b>3/11/59</b>
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Removal</b>		23b. DATE <b>3/11/59</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Graceland Cemetery.</b>
23d. LOCATION (City, town, or county) <b>Chicago, Ill.</b>		(State)	
24. FUNERAL DIRECTOR <b>Hedges Funeral Home Way, Mo.</b>		25. DATE RECD. BY LOCAL REG. <b>3-11-59</b>	26. REGISTRAR'S SIGNATURE <b>Paula Mae Anderson</b>

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

All diseases in Part I must be causally related.

APR 1 1958

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 *Clarence Moore* .....

Licensed Embalmer No. *4896* .....

P. O. Address *Waymire, W.* .....

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.