Health, Welfare Public Service

300 -57

THE DIVISION OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

59-012039
STATE FILE NUMBER

FILED APR 7 1959 Registration District No. 352 Primary Registration District No. ____ Registrar's No. 31

1. PLACE OF DEATH
a. COUNTY: TANEY
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN: BRANSON — Inside Limits: Yes [X] No [ ]
c. FULL NAME OF HOSPITAL OR INSTITUTION (If NOT in hospital, give location): Skaggs Hosp. — Length of stay in 1b: 1 day

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Missouri b. COUNTY: TANEY
c. CITY OR TOWN: CEDAR CREEK — Inside Limits: Yes [ ] No [X]
d. STREET ADDRESS (If outside, give location): rural — Reside on Farm: Yes [X] No [ ]

3. NAME OF DECEASED (Type or print): First: PEARL Middle: ALMER Last: STUART
4. DATE OF DEATH: Month: MARCH Day: 17 Year: 1959
5. SEX: Female
6. COLOR OR RACE: white
7. MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ]
8. DATE OF BIRTH: NOV. 16, 1889
9. AGE (In years last birthday): 69 — IF UNDER 1 YEAR: Months: 4 Days: 1 — 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: Housekeeping
11. BIRTHPLACE (City and state or country): TEXAS
12. CITIZEN OF WHAT COUNTRY? U. S. A.
13a. FATHER'S NAME: George McKenzie
13b. MOTHER'S MAIDEN NAME: Nancy Mosley
14. NAME OF HUSBAND OR WIFE: Frank Stuart
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): no (If yes, give war or dates of service): none
16. SOCIAL SECURITY NO.: none
17. INFORMANT: Frank Stuart Address: Cedar Creek, Mo

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Congestive Heart Failure — INTERVAL BETWEEN ONSET AND DEATH: 1 da.
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.
DUE TO (b): Hypertension — 6 yr.
DUE TO (c): Diabetes — 1 yr.
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a): 260X
19. WAS AUTOPSY PERFORMED? YES [ ] NO [X]

20a. ACCIDENT [ ] SUICIDE [ ] HOMICIDE [ ]
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)
20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year
20d. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]
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 3-16-59 to 3-17-59 and last saw her alive on 3-17-59
Death occurred at 9:50 p.m. on the date stated above; and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title): Hartley F. Mars MD
22b. ADDRESS: Forsyth
22c. DATE SIGNED: 3-18-59

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE: 3-21-59
23c. NAME OF CEMETERY OR CREMATORY: Brown Cemetery
23d. LOCATION (City, town, or county): Cedar Creek (State): Mo
24. FUNERAL DIRECTOR: W. S. Holt ADDRESS: Forsyth Mo
25. DATE RECD. BY LOCAL REG.: 4-3-59
26. REGISTRAR'S SIGNATURE: Helen Campbell

(Licensed Embalmer's Statement on Reverse Side)

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

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 S. Cobb

Licensed Embalmer No. 4731

P. O. Address Forsyth, Mo

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.