

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

59-012529

STATE FILE NUMBER

FILED APR 28 1959

Registration District No. 47

Primary Registration District No. 3068

Registrar's No. 123

300
1-57

1. PLACE OF DEATH a. COUNTY Callaway		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY Marion	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Fulton		c. CITY OR TOWN Hannibal	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION State Hospital #1		d. STREET ADDRESS (If outside, give location) 520 Winter Street	
3. NAME OF DECEASED (Type or print) First MARIE Middle STAUS Last HAYDEN		4. DATE OF DEATH Month April Day 23 Year 1959	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> 3 DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH August 22, 1912
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Nurse		10b. KIND OF BUSINESS OR INDUSTRY Nurse	11. BIRTHPLACE (City and state or country) Missouri
13a. FATHER'S NAME John Staus		13b. MOTHER'S MAIDEN NAME Minnie Schmidt	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) unk.		17. INFORMANT Address State Hospital #1; Fulton, Missouri	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Duodenum acute suppurative inflammation, ediology			INTERVAL BETWEEN ONSET AND DEATH
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. } DUE TO (b) _____ DUE TO (c) _____			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) Chronic Schizophrenic, Paranoid Type			
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 _____ a.m. _____ p.m. Month, Day, Year _____			
20d. INJURY OCCURRED WHILE AT <input type="checkbox"/> NOT WHILE WORK <input type="checkbox"/> 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 9-19-58 to 4-23-59 and last saw him on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE <i>H. G. Freund</i> (Degree or title) Harold G. Freund, M.D.		22b. ADDRESS State Hospital #1; Fulton, Mo.	
22c. DATE SIGNED 4-24-59			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE April 27, 1959	23c. NAME OF CEMETERY OR CREMATORY Greenwood Cemetery	23d. LOCATION (City, town, or county) (State) Palmira Mo.
24. FUNERAL DIRECTOR Maupin Funeral Home, Fulton, Mo.		25. DATE RECD. BY LOCAL REG. April 25-1959	
		26. REGISTRAR'S SIGNATURE <i>Maretha Lawrence</i>	

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

(Licensed Embalmer's Statement on Reverse Side)

MAY 1 1938

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 *Paul C. Blackwell*

Licensed Embalmer No. *4713*
P. O. Address *Fullon, Va*

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.