

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

59-014118
STATE FILE NUMBER

FILED MAY 1 1959 Registration District No. 209 Primary Registration District No. 3043 Registrar's No. 117

1. PLACE OF DEATH a. COUNTY MARION		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MISSOURI b. COUNTY PIKE	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN HANNIBAL		c. CITY OR TOWN FRANKFORD	
c. FULL NAME OF (IF NOT in hospital, give location) HOSPITAL OR INSTITUTION LEVERING HOSPITAL		d. STREET ADDRESS (If outside, give location)	
Length of stay in lb 4 DAYS		Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>	

3. NAME OF DECEASED (Type or print) First Middle Last MARY RUBY EPPERSON			4. DATE OF DEATH Month Day Year APRIL 15 1959		
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5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH OCT 5 - 1896	9. AGE (In years last birthday) 62	FUNDER YEAR Months Days Hours Min.	IF UNDER 24 HRS.
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) FACTORY WORKER (RETIRED)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and state or country) RALLS Co, MISSOURI	12. CITIZEN OF WHAT COUNTRY? U.S.A.
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13a. FATHER'S NAME RUEBEN HOLLIDAY	13b. MOTHER'S MAIDEN NAME NORA LILLY STAMBAUGH	14. NAME OF HUSBAND OR WIFE BERT EPPERSON
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15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No	16. SOCIAL SECURITY NO. 492-240925	17. INFORMANT Address MRS J.C. LUCAS FRANKFORD Mo.
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18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Uremia		INTERVAL BETWEEN ONSET AND DEATH
DUE TO (b) Hypertension		
DUE TO (c)		
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"/>

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.)
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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
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21. I attended the deceased from **May 1958** to **15 April 1959** and last saw her alive on **15 April 1959**
Death occurred at **6:15 AM** m on the date stated above; and to the best of my knowledge, from the causes stated.

22a. SIGNATURE Wyneth Hamilton M.D.	22b. ADDRESS Hannibal Mo	22c. DATE SIGNED 4/21/59
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23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	23b. DATE APRIL 17 - 59	23c. NAME OF CEMETERY OR CREMATORY FAIRVIEW CEMETERY	23d. LOCATION (City, town, or county) (State) FRANKFORD Mo.
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24. FUNERAL DIRECTOR J.P. Negason	ADDRESS Frankford Mo.	25. DATE RECD. BY LOCAL REG. 4-21-59	26. REGISTRAR'S SIGNATURE Walter M. Tucker By W.C. Fisher
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(Licensed Embalmer's Statement on Reverse Side)

300
1-57

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

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 *Jane Fields Meador*

Licensed Embalmer No. *4093*

P. O. Address *Frankford Md*

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.