

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

59-016518
STATE FILE NUMBER

RECEIVED APR 28 1959

Registration District No. 360 Primary Registration District No. 3076 Registrar's No. 90

300
1-57

1. PLACE OF DEATH a. COUNTY <u>Vernon</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Vernon</u>	
b. CITY OR TOWN <u>Nevada, Mo.</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		c. CITY OR TOWN <u>Nevada, Mo.</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (IF NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>Tate Nursing Home</u>		d. STREET ADDRESS (If outside, give location) <u>505 N. Cedar St</u>	
Length of stay in lb <u>40 years</u>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	

3. NAME OF DECEASED (Type or print) First Middle Last <u>Susan Anthony Dade</u>			4. DATE OF DEATH Month Day Year <u>4-17-1959</u>		
5. SEX <u>Female</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Oct. 26, 1914</u>	9. AGE (In years last birthday) <u>44</u>	IF UNDER 1 YEAR: Months <u>0</u> Days <u>22</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Insurance</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>retired</u>	11. BIRTHPLACE (City and state or country) <u>Versailles Mo</u>	12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	

13a. FATHER'S NAME <u>James Spurlock</u>		13b. MOTHER'S MAIDEN NAME <u>Clarenda Talbot</u>		14. NAME OF HUSBAND OR WIFE <u>Deceased</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) <u>no</u>		16. SOCIAL SECURITY NO. <u>none</u>	17. INFORMANT Address <u>Los Angeles Calif</u> <u>William Dade</u>		

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Arteriosclerotic & Hypertensive cardiovascular disease</u>			INTERVAL BETWEEN ONSET AND DEATH <u>unknown</u>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____			<u>443X</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>Cerebral arteriosclerosis, severe; Diabetes Mellitus.</u>			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.)		
20c. TIME OF INJURY Hour _____ a.m. _____ p.m.			
20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE 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 July 1955 to April 17, 1959 and last saw her alive on April 17, 1959
Death occurred at 4:50 PM on the date stated above; and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) <u>James J. Passer, MD</u>	22b. ADDRESS <u>Nevada, Mo.</u>	22c. DATE SIGNED <u>April 20, 1959</u>
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23a. BURIAL, CREMATION, REINTERMENT (Specify) <u>Burial</u>	23b. DATE <u>4-20-1959</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Newton Burial Park</u>	23d. LOCATION (City, town, or county) (State) <u>Nevada Missouri</u>
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24. FUNERAL DIRECTOR <u>Hayes Funeral Service, Inc.</u>	25. DATE RECD. BY LOCAL REG. <u>4-21-1959</u>	26. REGISTRAR'S SIGNATURE <u>Anna E. Perry</u>
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Nevada, Mo.
(Licensed Embalmer's Statement on Reverse Side)

Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed. All diseases in Part I must be causally related.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

6381 MAY 1 AM

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 *Richard Schiffer*

Licensed Embalmer No. *5053*
P. O. Address *H-20716*

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.