

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

59-018159
STATE FILE NUMBER

FILED MAY 18 1959

Registration District No. 157 Primary Registration District No. 3028 Registrar's No. 94

1. PLACE OF DEATH a. COUNTY Jasper		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY Jasper	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Carthage		c. CITY OR TOWN Carthage	
Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION 321 Bois D'Arc		Length of stay in 1b 75 yrs	
d. STREET ADDRESS 321 Bois D'Arc		e. (If outside, give location) 321 Bois D'Arc	
Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>			
3. NAME OF DECEASED First Middle Last MARTHA E HERRON			4. DATE OF DEATH Month Day Year May 3, 1959
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 Dec 6, 1870
9. AGE (In years at birthday) 88		10. F UNDER 1 YEAR Months Days	11. IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) at home		10b. KIND OF BUSINESS OR INDUSTRY ---	11. BIRTHPLACE (City and state or country) Franklin Co., Indiana
12. CITIZEN OF WHAT COUNTRY? USA			
13a. FATHER'S NAME William W. Etter		13b. MOTHER'S MAIDEN NAME Mary Ann Harper	14. NAME OF HUSBAND OR WIFE Joseph S. Herron
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. none	17. INFORMANT Address Carthage, Mo Lillian Herron. 321 Bois D'Arc
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Arteriosclerotic Heart Disease</i> DUE TO (b) <i>Arteriosclerosis</i> DUE TO (c) _____ Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.			INTERVAL BETWEEN ONSET AND DEATH 8-10 yrs. unknown
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.)	
20c. TIME OF INJURY Hour .Month, Day, Year a.m. p.m.			
20d. INJURY OCCURRED WHILE AT WORK <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 10-26-56 to May 3-1959 and last saw her alive on 5-1-59 Death occurred at 5:45 pm m on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE <i>Lillian Herron</i> MD		22b. ADDRESS Carthage, Mo	22c. DATE SIGNED 5-4-59
23a. BURIAL, CREMATION, REMOVAL (Specify) burial	23b. DATE May 5, 1959	23c. NAME OF CEMETERY OR CREMATORY Hackney Cemetery	23d. LOCATION (City, town, or county) Carthage, Mo (State)
24. FUNERAL DIRECTOR Address Kneel Mortuary, Carthage, Mo		25. DATE RECD. BY LOCAL REG. 5-5-59	26. REGISTRAR'S SIGNATURE <i>W. H. Clifton</i>

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

Director, Lubliner, etc. must use only standard manufacturer's steel 10. No symptoms will be traced. All diseases in Part I must be causally related.

MAY 5 0 5 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 *D. L. Isbell*

Licensed Embalmer No. *4970*

P. O. Address *Carlisle, 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.