Dept. Health, Soc., & Welfare
U. S. Public Health Service

V. S. 300
Rev. 1-57

THE DIVISION OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

59-020743
STATE FILE NUMBER

FILED JUN 19 1959

Registration District No. 75 Primary Registration District No. 3015 Registrar's No. 45

1. PLACE OF DEATH
a. COUNTY Clinton
b. CITY OR TOWN (If outside corporate limits, give TOWNSHIP only) Cameron, Missouri — Inside Limits Yes ☑ No ☐
c. FULL NAME OF HOSPITAL OR INSTITUTION (If NOT in hospital, give location) Warren Nursing Home — Length of stay in 1b 1½ years

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Missouri b. COUNTY Clinton
c. CITY OR TOWN Lathrop — Inside Limits Yes ☑ No ☐
d. STREET ADDRESS (If outside, give location) — Reside on Farm Yes ☐ No ☐

3. NAME OF DECEASED (Type or print) First Mary Middle Etna Last Gall

4. DATE OF DEATH Month May Day 13 Year 1959

5. SEX Female
6. COLOR OR RACE White
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☑ DIVORCED ☐
8. DATE OF BIRTH November 1, 1873
9. AGE (In years last birthday) 85 — IF UNDER 1 YEAR Months 6 Days 12 — 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 Home
11. BIRTHPLACE (City and state or country) Near Lawson, Missouri
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13a. FATHER'S NAME E. M. Robinett
13b. MOTHER'S MAIDEN NAME Susan Elflin
14. NAME OF HUSBAND OR WIFE —

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)
16. SOCIAL SECURITY NO. —
17. INFORMANT Ray Gall Address Turney, Missouri

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) Cerebral Hemorrhage — INTERVAL BETWEEN ONSET AND DEATH 2 months
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.
DUE TO (b) arteriosclerotic Heart Disease — 10 yrs
DUE TO (c)
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) 4200

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

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 8-25-1953, to 5-13-1959 and last saw her/him alive on 5-12-1959
Death occurred at 8:00 PM m on the date stated above; and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) G. H. Netherton MD
22b. ADDRESS Cameron Mo
22c. DATE SIGNED 5-29-59

23a. BURIAL, CREMATION, REMOVAL (Specify) Burial
23b. DATE May 15, 1959
23c. NAME OF CEMETERY OR CREMATORY Lathrop Cemetery
23d. LOCATION (City, town, or county) (State) Lathrop, Missouri

24. FUNERAL DIRECTOR ADDRESS De Moss Funk - Cameron Mo
25. DATE RECD. BY LOCAL REG. 6-5-59
26. REGISTRAR'S SIGNATURE Francis D Crawford

(Licensed Embalmer's Statement on Reverse Side)

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

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.

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 Orel Robinson

Licensed Embalmer No. 4232

P. O. Address Lathrop,

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.