

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

59-022100
STATE FILE NUMBER

Registration District No. 385 Primary Registration District No. 3039 Registrar's No. 56
JUL 2 1959

S. 300

1-59

Robert W. Smith, M.D.
USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE
MEDICAL CERTIFICATION
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.

1. PLACE OF DEATH a. COUNTY <u>Linn</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>CHARITON</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>MARCELINE</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <u>Mendon R.F.D</u> Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>St Francis Hosp.</u>		Length of stay in lb <u>6 hrs</u>	a2, d, e, c. STREET ADDRESS (If outside, give location) <u>9 mi South East</u> Reside on Farm Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Middle Last <u>Stella Irene MAY</u>			4. DATE OF DEATH Month Day Year <u>June 26 - 1959</u>
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Nov-12-1894</u>
9a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		9b. KIND OF BUSINESS OR INDUSTRY <u>House work</u>	9c. AGE (In years) IF UNDER 1 YEAR IF UNDER 24 HRS. last birthday Months Days Hours Min. <u>64 7 14</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>House work</u>	10c. BIRTHPLACE (City and state or country) <u>Mendon Mo</u>
11. BIRTHPLACE (City and state or country) <u>Mendon Mo</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13a. FATHER'S NAME <u>WM Harrison Fox</u>		13b. MOTHER'S MAIDEN NAME <u>MARY DAXTON</u>	14. NAME OF HUSBAND or wife <u>O.N. MAY</u>
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <input checked="" type="checkbox"/>	17. INFORMANT Address <u>O.N. MAY - Mendon Mo RFD</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>Coronary Thrombosis myocardial infarction</u> DUE TO (b) <u>Hypertensive Cardiovascular Disease</u> DUE TO (c) <u>4201</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>Pt. had a Vascular Infection 2 mos ago</u>			INTERVAL BETWEEN ONSET AND DEATH <u>2</u> 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT SUICIDE HOMICIDE <input type="checkbox"/> <input type="checkbox"/> <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. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
20e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		20f. CITY, TOWN, OR LOCATION COUNTY STATE	
21. I attended the deceased from <u>1955</u> to <u>6-26-59</u> and last saw her alive on <u>6-26-59</u> Death occurred at <u>2:00 p.m.</u> on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree or title) <u>Robert W. Smith, MD</u>		22b. ADDRESS <u>Marceline, MO</u>	22c. DATE SIGNED <u>6-27-59</u>
23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE <u>6/29/59</u>	23c. NAME OF CEMETERY OR CREMATORY <u>POWELL</u>	23d. LOCATION (City, town, or country) (State) <u>9 mi South East Mendon Mo</u>
24. FUNERAL DIRECTOR ADDRESS <u>A. A. Deipang Mendon Mo</u>		25. DATE RECD. BY LOCAL REG. <u>6-27-59</u>	26. REGISTRAR'S SIGNATURE <u>Brookie Owens</u>

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 *Billie C. Gonder*.....

Licensed Embalmer No. *4980*.....

P. O. Address *Mendon, Mo.*

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.