

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

59-023806

STATE FILE NUMBER

FILED JUN 29 1959 Registration District No. 325 Primary Registration District No. 447-8 Registrar's No. 17

1. PLACE OF DEATH a. COUNTY <u>Schuyler</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Schuyler</u>				
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Lancaster Mo</u>		Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>		c. CITY OR TOWN <u>Lancaster Mo</u>		Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>		
c. FULL NAME OF (If NOT in hospital, give location) INSTITUTION <u>Home</u>			Length of stay in 1b		d. STREET ADDRESS <u>N.E. of Lancaster</u>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Margaret</u> Middle <u>Jones</u> Last <u>Jones</u>				4. DATE OF DEATH Month <u>June</u> Day <u>21</u> Year <u>1959</u>				
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Nov 12 1871</u>		9. AGE (In years last birthday) <u>87</u>	IF UNDER 1 YEAR Months <u>7</u> Days <u>9</u> Hours <u></u> Min. <u></u>	IF UNDER 24 HRS. Hours <u></u> Min. <u></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>Housewife</u>		11. BIRTHPLACE (City and state or country) <u>Indiana</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		
13. FATHER'S NAME <u>Comer Moberly</u>				14. MOTHER'S MAIDEN NAME <u>Annie Stogdill</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. <u>None</u>		17. INFORMANT Name <u>Perley Burris</u> Address <u>Lancaster, Mo</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>Transition and Debilitation</u>							INTERVAL BETWEEN ONSET AND DEATH <u>2 weeks</u>	
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.		DUE TO (b) <u>Congestive heart failure</u>		DUE TO (c) <u>Atherosclerosis</u>		year <u></u> year <u></u>		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Chronic cholecystitis</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 <u></u> Month, Day, Year <u></u>								
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 <u>Nov. 21, 1956</u> to <u>June 21, 1959</u> and last saw her <u>alive</u> on <u>JUNE 21, 1959</u> Death occurred at <u>11:00</u> A. m on the date stated above; and to the best of my knowledge, from the causes stated.								
22a. SIGNATURE <u>H. R. Stoker, D.O.</u>				22b. ADDRESS <u>Lancaster, Missouri</u>		22c. DATE SIGNED <u>6-22-59</u>		
23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE <u>June 23 1959</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Ledford</u>		23d. LOCATION (City, town, or county) <u>Putnam Co</u>		STATE <u>Mo</u>		
24. FUNERAL DIRECTOR <u>Normans Lancaster MO</u>			25. DATE RECD. BY LOCAL REG. <u>6. 22. 59</u>		26. REGISTRAR'S SIGNATURE <u>Wm. B. Drake</u>			

(Licensed Embalmer's Statement on Reverse Side)

Health, Welfare Public Service
300 1-56
Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed. All diseases in Part I must be casually related. Coroner cannot certify to a death due to natural causes.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

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 *Frank Foster*

Licensed Embalmer No. *474*
P. O. Address *Furk... ..*

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (If
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.