

RI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

59-031884

FILED VS OCT 2 1959

Registration District No. 100 Primary Registration District No. 3018 Registrar's No. 4970 STATE FILE NUMBER

1. PLACE OF DEATH a. COUNTY <u>Dent</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. <u>Missouri</u> b. COUNTY <u>Dent</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Salem</u>		Length of stay in lb <u>1 wk</u>	c. CITY OR TOWN <u>Salem</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>ast Warfel</u>		Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	d. STREET ADDRESS <u>rt 5</u> (If outside, give location) Residence on Farm Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>

3. NAME OF DECEASED (Type or print) First <u>Anna</u> Middle <u>Hoodenpyle</u> Last <u>Stagner</u>			4. DATE OF DEATH Month <u>Sept</u> Day <u>29</u> Year <u>1959</u>		
---	--	--	--	--	--

5. SEX <u>72. 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>Feb 8-91 68</u>	9. AGE (last birthday) <u>68</u>	IF UNDER 1 YEAR Months <u>0</u> Days <u>0</u>	IF UNDER 24 HR Hours <u>0</u> Min. <u>0</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>X</u>	11. BIRTHPLACE (City and state or country) <u>Dent Co Missouri U S A</u>	12. CITIZEN OF WHAT COUNTRY <u>U S A</u>
---	---	---	---

13a. FATHER'S NAME <u>Andrew Hoodenpyle</u>	13b. MOTHER'S MAIDEN NAME <u>Nancy Gibbons</u>	14. NAME OF HUSBAND OR WIFE <u>Edd Stagner</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>X</u>	17. INFORMANT <u>Edd Stagner rt 5 Salem Mo</u> Address
---	----------------------------------	--

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY:		INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a) <u>Pulmonary Carcinoma</u>	DUE TO (b) _____	
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. } DUE TO (c) _____		

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)		PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
---	--	--

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.	Month, Day, Year _____
---	------------------------

20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" 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 9/21/59 to 9/28/59 and last saw her alive on 9/28/59
Death occurred at 10:15 P m on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE <u>Martin Mart M</u> (Signer's title)	22b. ADDRESS <u>Salem Mo.</u>	22c. DATE SIGNED <u>10/1/59</u>
--	-------------------------------	---------------------------------

23a. BURIAL, CREMATION, REMOVAL (Specify) <u>burial</u>	23b. DATE <u>9-1-59</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Dry Fork Cem</u>	23d. LOCATION (City, town, or county) <u>Dent Co Mo</u> (State)
--	-------------------------	---	--

24. FUNERAL DIRECTOR <u>Spencer Funeral Home Inc</u> ADDRESS	25. DATE RECD. BY LOCAL REG. <u>10/1/59</u>	26. REGISTRAR'S SIGNATURE <u>M.M. Hart, M.D. ans</u>
--	---	---

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by
or by _____, Student Embalmer No. _____
working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed David J. [Signature]

Licensed Embalmer No. 237

P. O. Address [Signature]

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to do so 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.