URI DIVISION OF HEALTH – STANDARD CERTIFICATE OF DEATH

FILED VS OCT 21 1959

59-038640

STATE FILE NUMBER

AMENDED

Registration District No. 340 Primary Registration District No. 6152 Registrar's No. 90

1. PLACE OF DEATH
a. COUNTY STODDARD
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN — Length of stay in 1b
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION GREEN MEADOWS REST HOME — Inside Limits Yes ☐ No ☒

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE MO b. COUNTY DUNKLIN
c. CITY OR TOWN MALDEN — Inside Limits Yes ☐ No ☐
d. STREET ADDRESS (If outside, give location) 205 N. EDWARDS — Reside on Farm Yes ☐ No ☐

3. NAME OF DECEASED (Type or print) First MARY Middle ADDIE Last CLARK

4. DATE OF DEATH Month SEPT Day 27 Year 1959

5. SEX FEMALE
6. COLOR OR RACE WHITE
7. Married ☐ Never Married ☐ Widowed ☒ Divorced ☐
8. DATE OF BIRTH 3-23-78
9. AGE (last birthday) 81
IF UNDER 1 YEAR Months Days — IF UNDER 24 HR 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) HARRISBURG, ILL
12. CITIZEN OF WHAT COUNTRY U.S.A.

13a. FATHER'S NAME D.T. WILSON
13b. MOTHER'S MAIDEN NAME MATILDA
14. NAME OF HUSBAND OR WIFE DECEASED

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO (If yes, give war or dates of service) NO
16. SOCIAL SECURITY NO. UNKNOWN
17. INFORMANT GLADYS ROSSI, ST. LOUIS, MO. Address

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 24 hr.
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.
DUE TO (b) Cerebral arteriosclerosis — 11 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)
PART III. If deceased was female was there a pregnancy in last 90 days. ☐ Yes ☐ No ☐ Unknown

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 1954, to 1959 and last saw her/him alive on Sept 27 1959
Death occurred at 7:30 P.m. on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE Wayne Coan MD (Degree or title)
22b. ADDRESS Malden Mo
22c. DATE SIGNED 10-4-59

23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL
23b. DATE 9-30-59
23c. NAME OF CEMETERY OR CREMATORY MEMORIAL PARK
23d. LOCATION (City, town, or county) (State) MALDEN, MO.

24. FUNERAL DIRECTOR DAY&KNIGHT FUNERAL, MALDEN, MO. ADDRESS
25. DATE RECD. BY LOCAL REG. 10-17-59
26. REGISTRAR'S SIGNATURE Anita M. Darner Dep Reg.

(Licensed Embalmer's Statement on Reverse Side)

DOCUMENT

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 m

or by _____, Student Embalmer No._____

working under my personal supervision.

Student_____
Signature of Student Embalmer

Signed J. R. Schauman

Licensed Embalmer No. 4086

P. O. Address Malden

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