

UNIFORM DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

FILED VS NOV 23 1959

59-038958

STATE FILE NUMBER

Registration District No. 37 Primary Registration District No. 4049 Registrar's No. 51

INDEXED

1. PLACE OF DEATH a. COUNTY <u>Boone</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Callaway</u>				
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Centralia</u>		Length of stay in 1b <u>47 days</u>		c. CITY OR TOWN <u>Fulton,</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>601 East Switzer</u>			Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS <u>400 DAK Street</u>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>CLARA</u> Middle <u>ETTA</u> Last <u>CUSTARD</u>				4. DATE OF DEATH Month <u>November</u> Day <u>20</u> Year <u>1959</u>				
5. SEX <u>Female</u>	6. COLOR OR RACE <u>white</u>	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <u>18 Nov. 1866</u>	9. AGE (last birthday) <u>93</u>	IF UNDER 1 YEAR Months <u> </u> Days <u> </u>	IF UNDER 24 HR Hours <u> </u> Min. <u> </u>		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>House wife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u> </u>		11. BIRTHPLACE (City and state or country) <u>Ohio</u>		12. CITIZEN OF WHAT COUNTRY <u>USA</u>		
13a. FATHER'S NAME <u>Eli Anna</u>			13b. MOTHER'S MAIDEN NAME <u>Sallie Robinson</u>			14. NAME OF HUSBAND OR WIFE <u>Custard</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 <u>Walter Custard - Fulton Missouri</u>				
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>arteriosclerotic heart disease</u>								
DUE TO (b) <u>with cardiac decompensation</u>							<u>5 days</u>	
DUE TO (c) <u> </u>								
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>cerebral arteriosclerosis</u>						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.) <u> </u>				
20c. TIME OF INJURY Hour <u> </u> a.m. <u> </u> p.m.		Month, Day, Year <u> </u> / <u> </u> / <u> </u>						
20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/>		20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <u> </u>		20f. CITY, TOWN, OR LOCATION <u> </u>		COUNTY <u> </u> STATE <u> </u>		
21. I attended the deceased from <u>11/17/59</u> to <u>11/17/59</u> and last saw her/him alive on <u>11/20/59</u> Death occurred at <u>7:30</u> a.m. on the date stated above, and to the best of my knowledge, from the causes stated.								
22a. SIGNATURE <u>Felt L. Ward MD</u> (Degree or title)				22b. ADDRESS <u>Centralia, Missouri</u>		22c. DATE SIGNED <u>11-20-59</u>		
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE <u>22 Nov 1959</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Hillcrest</u>		23d. LOCATION (City, town, or county) (State) <u>Fulton Missouri</u>			
24. FUNERAL DIRECTOR <u>Wallace Funeral Home</u> ADDRESS <u>Fulton, Mo.</u>			25. DATE RECD. BY LOCAL REG. <u>Nov. 20 - 1959</u>		26. REGISTRAR'S SIGNATURE <u>Maud Mc Bride</u>			

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

668108 AON SA

JUN 13 1960

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

A. P. Mauer

Licensed Embalmer No. 4996

P. O. Address. Fulton, Md.

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.