

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **4181**

FILED MAR 5 1957

BIRTH NO. _____ REG. DIST. NO. **99** PRIMARY REG. DIST. NO. **5379** Registrar's No. **29**

1. PLACE OF DEATH a. COUNTY DeKalb		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Mo b. COUNTY DeKalb	
b. CITY OR TOWN Clarkedale Sherman TWP, life		c. CITY OR TOWN Clarkedale Rural Sherman	
d. FULL NAME OF HOSPITAL OR INSTITUTION Home		d. STREET ADDRESS (If rural, give location) 7 Mi. N.E.	

3. NAME OF DECEASED (Type or Print) a. (First) Veronica b. (Middle) Lydia c. (Last) Dishman			4. DATE OF DEATH (Month) (Day) (Year) 2-19-57		
5. SEX Female	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Widowed	8. DATE OF BIRTH 12-25-1885	9. AGE (In years last birthday) 71	IF UNDER 1 YEAR Months Days 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 (State or foreign country) Mo	12. CITIZEN OF WHAT COUNTRY? U.S.A.	

13a. FATHER'S NAME Frank Carroll	13b. MOTHER'S MAIDEN NAME Francis Carroll	14. NAME OF HUSBAND OR WIFE none
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no	16. SOCIAL SECURITY NO. XXXXXX	17. INFORMANT'S SIGNATURE OR NAME Clayton Dishman	ADDRESS Clarkedale Mo
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18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) <i>*This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.</i>	MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Burned in house fire		
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____		
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		9160	

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
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21a. ACCIDENT, SUICIDE, HOMICIDE (Specify) X	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) home	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE) Clarkedale DeKalb Mo
21d. TIME OF INJURY 3 19 57 8P.m.	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>	21f. HOW DID INJURY OCCUR? House burned. She was trapped inside

22. I hereby certify that I attended the deceased from _____, 19____, to _____, 19____, that I last saw the deceased alive on _____, 19____, and that death occurred at _____ m., from the causes and on the date stated above.

22a. SIGNATURE [Signature]	(Degree or title) Coroner	23b. ADDRESS Maysville Mo	23c. DATE SIGNED 3-20-57
24a. BURIAL, CREMATION, REMOVAL (Specify) Burial	24b. DATE 3-22-57	24c. NAME OF CEMETERY OR CREMATORY Clarkedale	24d. LOCATION (City, town, or county) (State) Clarkedale Mo.
DATE REC'D BY LOCAL REG. 3-1-57	REGISTRAR'S SIGNATURE [Signature]	25. FUNERAL DIRECTOR'S SIGNATURE [Signature]	ADDRESS Maysville Mo

WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

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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
Student Embalmer

Signed _____

Licensed Embalmer No. 3933

P. O. Address Maysville 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 this body is not embalmed, fact should be so stated above.