

Health,
& Welfare
Public
Service

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

58-017024
STATE FILE NUMBER

FILED MAY 6 1958

Registration District No. 336 Primary Registration District No. 6128 Registrar's No. 457

300
1-57
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1. PLACE OF DEATH a. COUNTY <u>Shannon</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Shannon</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Eminence</u>		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <u>Eminence</u> <u>1019</u> Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>Home</u>		Length of stay in 1b <u>years</u>	d. STREET ADDRESS (If outside, give location) Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print) First <u>Mary</u> Middle <u>Ellen</u> Last <u>Lawson</u>	4. DATE OF DEATH Month <u>April</u> Day <u>2</u> Year <u>1958</u>
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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>Jan. 14, 1878</u>	9. AGE (In years last birthday) <u>80</u>	IF UNDER 1 YEAR Months <u>0</u> Days <u>0</u>	IF UNDER 24 HRS. Hours <u>0</u> Min. <u>0</u>
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10a. USUAL OCCUPATION (Give kind of work done during 1 year immediately preceding death, even if retired) <u>Housewife</u>	10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>	11. BIRTHPLACE (City and state or country) <u>Summersville, Missouri</u>	12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>
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13a. FATHER'S NAME <u>Wm. House</u>	13b. MOTHER'S MAIDEN NAME <u>Nancy Smith</u>	14. NAME OF HUSBAND OR WIFE <u>deceased</u>
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15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>no</u> <u>no</u>	16. SOCIAL SECURITY NO. <u>none</u>	17. INFORMANT <u>Roy Lawson, Lemont, Illinois</u>	Address
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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>Cerebral hemorrhage</u> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. } DUE TO (b) <u>chronic hypertension</u> DUE TO (c) <u>Arterio sclerosis</u> <u>33 1/2</u> years		INTERVAL BETWEEN ONSET AND DEATH <u>32 hrs</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)		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.)
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20c. TIME OF INJURY Hour <u>8:15</u> Month <u>Nov.</u> Day <u>11</u> Year <u>1952</u> a.m. p.m.	20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	20f. CITY, TOWN, OR LOCATION <u>Eminence Mo</u>	COUNTY <u>Shannon</u>	STATE <u>Missouri</u>
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20d. INJURY OCCURRED WHILE AT <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 <u>Eminence Mo</u>	COUNTY <u>Shannon</u>	STATE <u>Missouri</u>
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21. I attended the deceased from Death occurred at <u>8:15 p.m.</u> on <u>Nov. 11</u> 1952 to <u>date of death</u> and last saw her alive on <u>4/2/58</u> m on the date stated above; and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) <u>O. F. Wilson M.D.</u>	22b. ADDRESS <u>Eminence Mo</u>	22c. DATE SIGNED <u>4/29/58</u>
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23a. BURIAL, CREMATION, REINTERMENT (Specify) <u>burial</u>	23b. DATE <u>4/5/58</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Muncel Chapel Cem.</u>	23d. LOCATION (City, town, or county) <u>Eminence, Missouri</u>
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24. FUNERAL DIRECTOR <u>Duncan Funeral Home, Min View Mo.</u>	ADDRESS	25. DATE RECD. BY LOCAL REG. <u>May 5, 1958</u>	26. REGISTRAR'S SIGNATURE <u>Nobel Pace</u>
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USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

Medical Certification
All diseases in Part I must be causally related.

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 

Licensed Embalmer No. 4325

P. O. Address Mt. View, Va.

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.