

Health,
& Welfare,
Public
Service

8

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

58-035202

STATE FILE NUMBER

FILED SEP 16 1958 Registration District No. 336 Primary Registration District No. 6131 Registrar's No.

300
1-57

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>Mountain View</u>		Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	c. CITY OR TOWN <u>Mountain View</u> 1010 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>Home</u>		Length of stay in lb <u>years</u>	d. STREET ADDRESS (If outside, give location) <u>Route 2</u> Reside on Farm Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>

3. NAME OF DECEASED (Type or print) First <u>Mary</u> Middle <u>J.</u> Last <u>Mansfield</u>			4. DATE OF DEATH Month <u>Aug.</u> Day <u>24</u> Year <u>1958</u>		
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5. SEX <u>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>Jan. 8, 1911</u>	9. AGE (In years (last birthday)) <u>47</u>	IF UNDER 1 YEAR Months <u>1</u> Days <u>1</u>	IF UNDER 24 HRS. Hours <u>1</u> Min. <u>0</u>
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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>Home</u>	11. BIRTHPLACE (City and state or country) <u>New Lebanon, Ind.</u>	12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>
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13a. FATHER'S NAME <u>C. S. Poppino</u>	13b. MOTHER'S MAIDEN NAME <u>Edna Jule</u>	14. NAME OF HUSBAND OR WIFE <u>Charlie Mansfield</u>
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15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, <u>no</u> or unknown) (If yes, give year or dates of service) <u>no</u>	16. SOCIAL SECURITY NO. <u>none</u>	17. INFORMANT <u>Charlie Mansfield, Mtn. View, Mo.</u> Address
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18. CAUSE OF DEATH (only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>uremia</u>		INTERVAL BETWEEN ONSET AND DEATH
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) <u>glomerulonephritis</u>	
	DUE TO (c) <u>Eclampsia</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>uremia - secondary</u>		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>10</u> Month <u>10</u> Day <u>10</u> Year <u>1957</u> a.m. <u>10</u> p.m.	20d. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	20f. CITY, TOWN, OR LOCATION <u>Willow Springs, Mo.</u>	COUNTY	STATE
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20d. INJURY OCCURRED WHILE AT WORK <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>Willow Springs, Mo.</u>	COUNTY	STATE
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21. I attended the deceased from <u>Oct 10, 1957</u> to <u>Aug 23, 1958</u> and last saw ^{her} _{him} alive on <u>Aug 23, 1958</u> Death occurred at <u>10</u> <u>10</u> <u>10</u> m on the date stated above; and to the best of my knowledge, from the causes stated.

22a. SIGNATURE <u>Harold W. Miller md</u> (Degree or title)	22b. ADDRESS <u>Willow Springs, Mo.</u>	22c. DATE SIGNED <u>9/9/58</u>
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23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>	23b. DATE <u>8/26/58</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Country Cemetery</u>	23d. LOCATION (City, town, or county) (State) <u>Carlisle, Indiana</u>
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24. FUNERAL DIRECTOR <u>Duncan Funeral Home Mtn View, Mo.</u>	ADDRESS	25. DATE RECD. BY LOCAL REG. <u>9-16-1958</u>	26. REGISTRAR'S SIGNATURE <u>Mabel R. [Signature]</u>
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USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE
All diseases in Part I must be causally related.

MEDICAL CERTIFICATION

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 *Richard G. Norton*

Licensed Embalmer No. *5029*
P. O. Address *Mtn View*

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.