

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

12394

STATE FILE NUMBER

FILED APR 22 1957

Registration District No. 53 Primary Registration District No. 3010 Registrar's No. 225

Health,  
& Welfare  
Public  
Service

S. 300  
V. 1-56

Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed. All diseases in Part I must be causally related. Coroner cannot certify to a death due to natural causes.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

1. PLACE OF DEATH a. COUNTY <u>Cape Girardeau</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> COUNTY <u>Cape Gir.</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Cape Girardeau</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		c. CITY OR TOWN <u>Jackson Mo</u> Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL INSTITUTE <u>Osteopathic Hosp 2da</u> Length of stay in lb		d. STREET ADDRESS (If outside, give location) <u>616 Greenberry</u> (If on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Mollie</u> Middle <u>D</u> Last <u>Sider</u>		4. DATE OF DEATH Month <u>April</u> Day <u>17</u> Year <u>1957</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</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>March 29-1867</u> 9. AGE (In years last birthday) <u>90</u> IF UNDER 1 YEAR Months <u>0</u> Days <u>18</u> IF UNDER 24 HRS. Hours <u>0</u> Min. <u>18</u>
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>Keeping Home</u>	
11. BIRTHPLACE (City and state or country) <u>Missouri</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Sidney Dancerty</u>		14. MOTHER'S MAIDEN NAME <u>Margaret Drum</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) <u>No.</u>		16. SOCIAL SECURITY NO. <u>none</u>	
17. INFORMANT <u>Mrs. Gabe Friedrich Jackson</u> Address			
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>Respiratory Failure</u>			INTERVAL BETWEEN ONSET AND DEATH <u>Immediate</u>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. } DUE TO (b) <u>Cerebral Thrombosis</u>			<u>51 hrs.</u>
DUE TO (c) <u>Arteriosclerosis</u>			<u>Sev. Yrs.</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>A. Hypostatic Pneumonia B. Senility.</u>			
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>332X</u>	
20c. TIME OF INJURY Hour <u>3:30</u> Month, Day, Year <u>Dec. 20, 1957</u> a. m. <u>A.</u> p. m.			
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 COUNTY STATE	
21. I attended the deceased from <u>Dec. 20, 1957</u> to <u>Apr. 17, 1957</u> and last saw <u>her</u> <u>him</u> alive on <u>4/16/57</u> Death occurred at <u>3:30 A.</u> m on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree or title) <u>Alfred W. Tindell, M.D.</u>		22b. ADDRESS <u>Jackson, Mo.</u>	
		22c. DATE SIGNED <u>4/19/57</u>	
23a. BURIAL, CREMATION, OR OTHER DISPOSITION (Specify) <u>Burial</u>		23b. DATE <u>4/19/57</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Fair View</u>		23d. LOCATION (City, town, or county) (State) <u>2 Mi. E. Fruitland Mo.</u>	
24. FUNERAL DIRECTOR <u>Denette Laird</u> ADDRESS <u>4-20-1957</u>		25. DATE RECD. BY LOCAL REG. <u>4-20-1957</u>	
		26. REGISTRAR'S SIGNATURE <u>C. C. Summers</u>	

(Licensed Embalmer's Statement on Reverse Side)

44-0

**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 *R. O. Laird* .....

Licensed Embalmer No. *453* .....

P. O. Address *Jackson, m* .....

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.