

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 10349

FILED APR 14 1953

BIRTH NO. 124 REG. DIST. NO. 1608 PRIMARY REG. DIST. NO. 5593 Registrar's No. 22

1. PLACE OF DEATH a. COUNTY Jefferson		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Mo. b. COUNTY Jeff.	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Platin Twp.		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Festus, Mo.	
d. FULL NAME OF HOSPITAL OR INSTITUTION R #1. Festus, Mo.		d. STREET ADDRESS (If rural, give location) R #1. Festus, Mo.	

3. NAME OF DECEASED (Type or Print) a. (First) Mahale b. (Middle) — c. (Last) DeClue			4. DATE OF DEATH (Month) (Day) (Year) 3 - 30 - 53		
---	--	--	--	--	--

5. SEX Female	6. COLOR OR RACE white	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Widowed	8. DATE OF BIRTH Dec. 15, 1894	9. AGE (In years last birthday) 78	IF UNDER 1 YEAR Months 3 Days 15	IF UNDER 6 WEEKS Hours Min.
---------------	------------------------	--	--------------------------------	------------------------------------	----------------------------------	-----------------------------

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housework	10b. KIND OF BUSINESS OR INDUSTRY own home	11. BIRTHPLACE (State or foreign country) Hamilton, Mo.	12. CITIZEN OF WHAT COUNTRY? U.S.A.
---	--	---	-------------------------------------

13a. FATHER'S NAME Thomas Jackson	13b. MOTHER'S MAIDEN NAME Sarah Hulsey	14. NAME OF HUSBAND OR WIFE Mrs. Harry Thurman Denton
-----------------------------------	--	---

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S SIGNATURE OR NAME Mrs. Harry Thurman Denton	ADDRESS
--	-------------------------	---	---------

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) *This does not mean the mode of dying, such as heart failure, asphyxia, etc. It means the disease, injury, or complication which caused death.	MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH 1 week
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Cardiovascular Syndrome</u>		
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <u>Myocarditis</u> DUE TO (c) <u>Arteriosclerosis</u>		
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION 442X	20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
------------------------	---------------------------------------	---

21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
--	--	---

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR
--	--	---------------------------

22. I hereby certify that I attended the deceased from 3/27, 1953, to 3/30, 1953, that I last saw the deceased alive on 3/30, 1953, and that death occurred at 3:30 A.M., from the causes and on the date stated above.

23a. SIGNATURE DeClue MD (Degree or title)	23b. ADDRESS	23c. DATE SIGNED 3/31/53
--	--------------	--------------------------

24a. BURIAL, CREMATION, REMOVAL (Specify) Burial	24b. DATE 4-1-53	24c. NAME OF CEMETERY OR CREMATORY Bonne Terre	24d. LOCATION (City, town, or county) (State) Bonne Terre, Mo.
--	------------------	--	--

DATE REC'D BY LOCAL REG. 4-1-53	REGISTRAR'S SIGNATURE Marie Farrer	25. FUNERAL DIRECTOR'S SIGNATURE Sentry R. Polette	ADDRESS Crystal City, Mo.
---------------------------------	------------------------------------	--	---------------------------

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

5500

JEFFERSON COUNTY HEALTH DEPT.
MILLSBORO, MISSOURI

DATE RECEIVED APR 7 1963

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.....

.....
working under my personal supervision.

Student Embalmer No.....

Signed.....
Student Embalmer

Signed Rentyn R. Polite

Licensed Embalmer No. 3481

P. O. Address Crystal City

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.