

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

58-045237

STATE FILE NUMBER

FILED JAN 6 1959 Registration District No. 297 Primary Registration District No. 3057 Registrar's No. 9

1-57

1. PLACE OF DEATH a. COUNTY <b>Ray</b>			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Missouri</b> b. COUNTY <b>Ray</b>		
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>Richmond</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <b>Richmond</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>181 Ralph St.</b>		Length of stay in lb <b>15 years</b>	d. STREET ADDRESS (If outside, give location) <b>181 Ralph St.</b>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <b>Flora</b> Middle <b>K.</b> Last <b>Archer</b>			4. DATE OF DEATH Month <b>December</b> Day <b>28</b> Year <b>58</b>		
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>10/16/1875</b>	9. AGE (In years last birthday) <b>83</b>	IF UNDER 1 YEAR Months <b>0</b> Days <b>0</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>at home</b>	11. BIRTHPLACE (City and state or country) <b>Clay Co. Missouri</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>
13a. FATHER'S NAME <b>Jacob Miller</b>		13b. MOTHER'S MAIDEN NAME <b>(unknown) Hauser</b>		14. NAME OF HUSBAND OR WIFE <b>Benjamin Archer</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>no</b>		16. SOCIAL SECURITY NO. <b>none</b>	17. INFORMANT Address <b>B.F. Archer Richmond, Missouri</b>		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary Thrombosis</b>					INTERVAL BETWEEN ONSET AND DEATH <b>hrs.</b>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <b>arteriosclerosis</b>					
DUE TO (c) <b>Senility</b>					
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.)			
20c. TIME OF INJURY Hour <b>7:30</b> Month <b>12</b> Day <b>28</b> Year <b>58</b> a.m. <input type="checkbox"/> p.m. <input checked="" type="checkbox"/>					
20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" 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 <b>9-10-58</b> to <b>12-28-58</b> and last saw her alive on <b>7-10-58</b> Death occurred at <b>7:30 pm</b> m on the date stated above; and to the best of my knowledge, from the causes stated.					
22a. SIGNATURE <b>Dr. Davault M.D.</b> (Degree or title)			22b. ADDRESS <b>Richmond</b>		22c. DATE SIGNED <b>12-30-58</b>
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE <b>12/30/58</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Woodland Cemetery</b>		23d. LOCATION (City, town, or county) (State) <b>Richmond, Missouri</b>
24. FUNERAL DIRECTOR <b>Quest Life Funeral Home</b> Address <b>Richmond, Missouri</b>			25. DATE RECD. BY LOCAL REG. <b>1-3-1959</b>		26. REGISTRAR'S SIGNATURE <b>Mabel Jackson</b>

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.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

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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 .....  
Signature of Student Embalmer

Signed *Morris D. Bailey* .....

Licensed Embalmer No. *4887* .....

P. O. Address *Richmond, 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.