Health, Welfare Public Service

300
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 casually related. Coroner cannot certify to a death due to natural causes.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

3600
STATE FILE NUMBER

FILED FEB 25 1957

Registration District No. 1 Primary Registration District No. 3000 Registrar's No. 69

1. PLACE OF DEATH
a. COUNTY: Adair
b. CITY OR TOWN (If outside corporate limits, give TOWNSHIP only): Kirksville — Inside Limits: Yes ✓ No ☐
c. FULL NAME OF HOSPITAL OR INSTITUTION (If NOT in hospital, give location): Laughlin — Length of stay in 1b: 1 day

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Kansas b. COUNTY: Shawnee
c. CITY OR TOWN: Willard — Inside Limits: Yes ✓ No ☐
d. STREET ADDRESS (If outside, give location): — Reside on Farm: Yes ☐ No ☐

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3. NAME OF DECEASED (Type or print): First: Stella Middle: B. Last: Vice

4. DATE OF DEATH: Month: Feb. Day: 16 Year: 1957

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED ☐ **NEVER MARRIED** ☐ **WIDOWED** ☐ **DIVORCED** ✓

8. DATE OF BIRTH: June 1, 1881

9. AGE (In years last birthday): 75 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10b. KIND OF BUSINESS OR INDUSTRY: —

11. BIRTHPLACE (City and state or country): Shelby Co. Mo.

12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: J. H. Montgomery

14. MOTHER'S MAIDEN NAME: Harriet Goodwin

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 Address: Mrs. Paul Hupton Sr. Shelbyville, Mo.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Myocardial Failure — INTERVAL BETWEEN ONSET AND DEATH: 12 hours
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.
DUE TO (b) Auricular Fibrillation — ?
DUE TO (c) — ?

4331

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 ☐ NO ✓

20a. ACCIDENT ☐ **SUICIDE** ☐ **HOMICIDE** ☐

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year

20d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

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 Feb 15, 1957 to Feb 16, 1957 and last saw her alive on Feb 16, 1957
Death occurred at 5:00 P m on the date stated above; and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title): U. T. Rhoads, DO

22b. ADDRESS: Kirksville, Mo

22c. DATE SIGNED: 2-16-57

23a. BURIAL, CREMATION, REMOVAL (Specify): Removal

23b. DATE: 2-16-1957

23c. NAME OF CEMETERY OR CREMATORY: —

23d. LOCATION (City, town, or county): Shelbyville (State): Mo.

24. FUNERAL DIRECTOR ADDRESS: Davis & Davis, Kirksville, Mo.

25. DATE RECD. BY LOCAL REG.: 2-16-1957

26. REGISTRAR'S SIGNATURE: Doris W. Ratliff

(Licensed Embalmer's Statement on Reverse Side)

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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 em

by me, or by ....., Student Embalmer No.....

working under my personal supervision..

Student.....
Signature of Student Embalmer

Signed Robert B. Davis

Licensed Embalmer No. 42

P. O. Address Kirksvil

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (I
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.