

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

57 021813
STATE FILE NUMBER

FILED JUN 27 1957

Registration District No. 200 Primary Registration District No. 3041 Registrar's No. 98

1. PLACE OF DEATH a. COUNTY <u>Macon</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Macon</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Macon</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <u>College Mound</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>Taylor R Home 6 Mon</u>		Length of stay in lb	d. STREET ADDRESS (If outside, give location) <u>No.</u> Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>

3. NAME OF DECEASED (Type or print) First <u>Rilla</u> Middle <u>Kitchen</u> Last			4. DATE OF DEATH Month <u>June</u> Day <u>19</u> Year <u>1957</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</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>Apr 9, 1873</u>	9. AGE (In years last birthday) <u>84</u>	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
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>no.</u>		11. BIRTHPLACE (City and state or country) <u>Randolph County Mo</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>
13. FATHER'S NAME <u>Calvin Smith</u>			14. MOTHER'S MAIDEN NAME <u>Margaret Richmond</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>No.</u>		17. INFORMANT Address <u>Tom Kitchen College Mound, Mo.</u>		

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>Uremia</u>		INTERVAL BETWEEN ONSET AND DEATH <u>3 mos</u>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) <u>Senility and prolonged recumbence</u>	<u>1 yr</u>
	DUE TO (c) <u>Fracture of Left Femur</u>	<u>1 yr</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>962x</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.) <u>patient fell at home</u> <u>21</u>	
20c. TIME OF INJURY Hour <u>Unknown</u> a. m. <u>Unknown</u> p. m. <u>Unknown</u>	20d. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) <u>Macon Missouri</u>	
20e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	20f. CITY, TOWN, OR LOCATION <u>Macon Missouri</u>	

21. I attended the deceased from <u>December</u> to <u>June 13, 1957</u> and last saw <u>her</u> alive on <u>June 13</u> Death occurred at <u>10:30 A. m</u> on the date stated above; and to the best of my knowledge, from the causes stated.		
22a. SIGNATURE <u>A. L. Durdan D.O.</u>	22b. ADDRESS <u>Macon, Missouri</u>	22c. DATE SIGNED <u>6/22/57</u>

23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE <u>June 21, 57</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Mt. Salem</u>	23d. LOCATION (City, town, or county) (State) <u>Excelsior Mo.</u>
24. FUNERAL DIRECTOR <u>Lester Hutton</u>	ADDRESS <u>Macon Mo.</u>	25. DATE RECD. BY LOCAL REG. <u>6/22/57</u>	26. REGISTRAR'S SIGNATURE <u>Ruth McNeely</u>

(Licensed Embalmer's Statement on Reverse Side)

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

MEDICAL CERTIFICATION

Date Filed 6.25.57

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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 e
by me, or by Student Embalmer No.
working under my personal supervision.

Student
Signature of Student Embalmer

Signed *Charles L. Hutto*

Licensed Embalmer No. *46*

P. O. Address *Macou*

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