

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

33055

STATE FILE NUMBER

FILED SEP 24 1957

Registration District No. 297 Primary Registration District No. 3057 Registrar's No. 103

1. PLACE OF DEATH a. COUNTY <u>Ray</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Ray</u>	
b. CITY (If outside corporate limits give TOWNSHIP only) OR TOWN <u>Richmond</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		c. CITY OR TOWN <u>Odessa</u> 1942 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>Clemens</u> Length of stay in 1b <u>6 da</u>		d. STREET ADDRESS (If outside, give location) <u>Not listed</u> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Mayme Ellen Tietjens</u> First <u>Ellen</u> Middle <u>Tietjens</u> Last <u>Mayme</u>		4. DATE OF DEATH <u>Sept 15 1957</u> Month <u>Sept</u> Day <u>15</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>June 8, 1884</u>
9a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		9b. KIND OF BUSINESS OR INDUSTRY <u>labor</u>	9c. AGE (In years last birthday) <u>73</u> IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.
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>labor</u>	10c. BIRTHPLACE (City and state or country) <u>Odessa, Mo.</u>
11. FATHER'S NAME <u>Robert Colvin</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Robert Colvin</u>		14. MOTHER'S MAIDEN NAME <u>Flecia Felix</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>none</u>	
17. INFORMANT <u>Mrs. Walter Kite, Odessa</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>Massive Cerebral Hemorrhage</u>		INTERVAL BETWEEN ONSET AND DEATH <u>24 hours</u>	
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <u>Arterial Sclerosis</u>		<u>4 yrs</u>	
DUE TO (c)			
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? <u>2</u> 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 a. m. 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>Sept 9, 57</u> to <u>Sept 15 - 57</u> and last saw her <u>alive</u> on <u>Sept 15, 57</u> Death occurred at <u>Richmond, Mo.</u> 2 P m on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree or title) <u>Dr. E. G. Kerner M.D.</u>		22b. ADDRESS <u>Richmond Mo.</u>	
22c. DATE SIGNED <u>9/15/57</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>removed</u>		23b. DATE <u>Sept. 1957</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Trunton</u>		23d. LOCATION (City, town, or county) (State) <u>Odessa Mo.</u>	
24. FUNERAL DIRECTOR <u>Ralph Jones, Odessa Mo</u> ADDRESS		25. DATE RECD. BY LOCAL REG. <u>Sept 17 - 1957</u>	
26. REGISTRAR'S SIGNATURE <u>Malul Jackson</u>			

17

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 *Ralph O Jones*

Licensed Embalmer No. *46*

P. O. Address *Odesa*

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.