

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

58-018952

STATE FILE NUMBER

FILED JUN 12 1958 Registration District No. 187 Primary Registration District No. 3240 Registrar's No. 174

1. PLACE OF DEATH a. COUNTY <i>Livingston</i>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Missouri</i> b. COUNTY <i>Livingston</i>			
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <i>Chillicothe</i>			Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <i>Chillicothe</i>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <i>Queens Nursing Home, 5 Mo.</i>			Length of stay in 1b	d. STREET ADDRESS (If outside, give location) <i>903 Broadway</i>			Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <i>RANNIE</i> Middle <i>F.</i> Last <i>RADER</i>				4. DATE OF DEATH Month <i>May</i> Day <i>31</i> Year <i>1958</i>			
5. SEX <i>Female</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <i>Apr. 12-1875</i>		9. AGE (In years last birthday) <i>83</i> 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) <i>Housewife</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>at Home</i>		11. BIRTHPLACE (City and state or country) <i>Carthage, Mo. D</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.</i>	
13. FATHER'S NAME <i>Richard Ferguson</i>				14. MOTHER'S MAIDEN NAME <i>Caroline Knight</i>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <i>XX XX</i>		16. SOCIAL SECURITY NO. <i>—</i>		17. INFORMANT <i>Mr. Walter Rader, 903 Broadway</i> Address <i>Chillicothe, Mo.</i>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Pneumonia Terminal bronchial bilateral</i> INTERVAL BETWEEN ONSET AND DEATH <i>1 day</i> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <i>Arterial Sclerosis Severe</i> <i>5960</i> DUE TO (c) <i>Cerebral Embolus, Paralysis Left and leg</i> <i>9 yr</i> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>332X</i> 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> <i>2</i>							
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 a. m. p. m. Month, Day, Year							
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 <i>June 15-49</i> to <i>May 31 '58</i> and last saw her alive on <i>May 27-58</i> Death occurred at <i>3:15</i> A. m. on the date stated above, and to the best of my knowledge, from the causes stated.							
22a. SIGNATURE (Degree or title) <i>Joseph A. Conrad M.D. D</i>				22b. ADDRESS <i>Chillicothe Mo</i>		22c. DATE SIGNED <i>June 6-58</i>	
23a. BURIAL, CREATION, REMOVAL (Specify)	23b. DATE <i>June 2-1958</i>	23c. NAME OF CEMETERY OR CREMATORY <i>Masonic</i>		23d. LOCATION (City, town, or county) <i>Jamesport Mo.</i>		(State)	
24. FUNERAL DIRECTOR <i>R. Roberson Jamesport Mo</i>		ADDRESS		25. DATE RECD. BY LOCAL REG. <i>6-9-58</i>		26. REGISTRAR'S SIGNATURE <i>Frances B Neill</i>	

(Licensed Embalmer's Statement on Reverse Side)

Health, Welfare, Public Service

300 1-56

All 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

Director, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed.

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 *O. L. Roberson*.....

Licensed Embalmer No. *32*.....

P. O. Address *Imperial*.....

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.