

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

58-024446  
STATE FILE NUMBER

FILED AUG 4 1958

Registration District No. 1 Primary Registration District No. 3000 Registrar's No. 246

300  
1-57

0013  
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All diseases in Part I must be causally related.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

1. PLACE OF DEATH a. COUNTY <u>Adair</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>Kirksville</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <u>LaPlata</u>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>Grim-Smith Hospital</u>		Length of stay in 1b <u>2 Das.</u>	d. STREET ADDRESS (If outside, give location) Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <u>David</u> Middle <u>Sims</u> Last <u>Christie</u>			4. DATE OF DEATH Month <u>7</u> Day <u>27</u> Year <u>58</u>
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> / DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>7-23-77</u>
9. AGE (In years last birthday) <u>81</u>		IF UNDER 1 YEAR Months <u>0</u> Days <u>0</u>	IF UNDER 24 HRS. Hours <u>0</u> Min. <u>0</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Undertaker</u>		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and state or country) <u>Macon County, Missouri</u>
12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>		13a. FATHER'S NAME <u>James Christie</u>	
13b. MOTHER'S MAIDEN NAME <u>Malvinia Swarthout</u>		14. NAME OF HUSBAND OR WIFE <u>Ethel Goding Christie</u>	
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. <u>486-38-7043</u>	17. INFORMANT Address <u>Hospital Records Kirksville, 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>Coronary Thrombosis</u> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. } DUE TO (b) <u>Chronic Myocardial degeneration</u> DUE TO (c) <u>Arteriosclerosis</u> <u>4201</u>			INTERVAL BETWEEN ONSET AND DEATH
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 <u>    </u> Month, Day, Year a.m. <u>    </u> p.m. <u>    </u>		20d. INJURY OCCURRED WHILE AT <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>July 25</u> to <u>July 27</u> and last saw <sup>xxxx</sup> him alive on <u>7-27-58</u> Death occurred at <u>Grim Smith Hospital &amp; Cl.</u> on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE <u>O.W. Hasselblad</u> <u>O.W. Hasselblad</u>		22b. ADDRESS <u>Kirksville, Missouri</u>	22c. DATE SIGNED <u>7-27-58</u>
23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE <u>7-30-58</u>	23c. NAME OF CEMETERY OR CREMATORY <u>LaPlata</u>	23d. LOCATION (City, town, or county) (State) <u>LaPlata Mo</u>
24. FUNERAL DIRECTOR <u>H. H. McCallum</u>		25. DATE RECD. BY LOCAL REG. <u>7-30-58</u>	26. REGISTRAR'S SIGNATURE <u>Doris W. Pattiff</u>

**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 *A. H. McCullum*

Licensed Embalmer No. *7053*  
P. O. Address *South St. G. Fla*

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.