

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

58-037170

STATE FILE NUMBER

FILED NOV 3 1958 Registration District No. 217 Primary Registration District No. 3045 Registrar's No. 74

1. PLACE OF DEATH a. COUNTY Mississippi		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY Mississippi	
b. CITY (If outside corporate limits, give TOWNSHIP only) Charleston		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN Charleston
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION 1001 E. Cypress		Length of stay in lb 20 Month	664 STREET ADDRESS (If outside, give location) 1001 E. Cypress
			Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print) First Ethel Middle Eulalah Last Rushing			4. DATE OF DEATH Month 10 Day 13 Year 58		
--	--	--	--	--	--

5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 2/19/1896	9. AGE (In years (last birthday)) 62	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) House Wife	10b. KIND OF BUSINESS OR INDUSTRY At Home	11. BIRTHPLACE (City and state or country) Mississippi County, Mo. USA	12. CITIZEN OF WHAT COUNTRY? USA
--	---	--	--

13a. FATHER'S NAME C.D. Jackson	13b. MOTHER'S MAIDEN NAME Jennie Ward	14. NAME OF HUSBAND OR WIFE
---	---	-----------------------------

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No	16. SOCIAL SECURITY NO. None	17. INFORMANT Mrs. Glenn Ault, Charleston, Mo.	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) Ac. Coronary Insufficiency		INTERVAL BETWEEN ONSET AND DEATH 2 hrs
--	--	--

Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) Ac. Myocarditis	4201F
	DUE TO (c) associated w Ac. Hemorrhage from Peptic ulcer	

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) Rheumatoid Arthritis 20 yrs Freed of insulin 6/5/58		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 Month, Day, Year a.m. p.m.	
--	--

20d. INJURY OCCURRED WHILE AT <input type="checkbox"/> NOT WHILE WORK <input type="checkbox"/> 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 Charleston, Mo.	COUNTY Mississippi	STATE
---	--	--	------------------------------	-------

21. I attended the deceased from 6/5/58 to 10/13/58 and last saw her alive on 10/13/58 Death occurred at 2:10 P m on the date stated above; and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) E. Charles Solving MD	22b. ADDRESS Charleston Mo	22c. DATE SIGNED 10/14/58
--	--------------------------------------	-------------------------------------

23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE 10/15/58	23c. NAME OF CEMETERY OR CREMATORY I.O.O.F. Cemetery	23d. LOCATION (City, town, or county) Charleston, Mo.	(State)
--	------------------------------	--	---	---------

24. FUNERAL DIRECTOR The Nunnelee Funeral Chapel Charleston, Mo.	25. DATE RECD. BY LOCAL REG. 11-1-58	26. REGISTRAR'S SIGNATURE Dorothy B. Hathorn
---	--	--

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

0
1
2
3
4
5
6
7
8
9
All diseases in Part I must be causally related.

300
1-57

Date Filed 11/5/58

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 *John F. Annelle*

Licensed Embalmer No. *3851*

P. O. Address *Charlestown*

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.