

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

59-000268

STATE FILE NUMBER

JAN 12 1959

Registration District No. 042 Primary Registration District No. 1000 Registrar's No. 21

5. 300
1-57

1. PLACE OF DEATH a. COUNTY <u>Buchanan</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Andrew</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>St Joseph</u>		c. CITY OR TOWN <u>Rosendale</u>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>Missouri Methodist</u>		d. STREET ADDRESS (If outside, give location) <u>24 days</u>	

3. NAME OF DECEASED (Type or print) First Middle Last <u>Edna Deaton</u>			4. DATE OF DEATH Month Day Year <u>1-5-1959</u>			
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5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>10-21-1885</u>	9. AGE (In years last birthday) <u>73</u>	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Hours Min.
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>At Home</u>	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and state or country) <u>Rosendale</u>	12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>
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13a. FATHER'S NAME <u>Thomas B Howard</u>	13b. MOTHER'S MAIDEN NAME <u>Mary Paden</u>	14. NAME OF HUSBAND OR WIFE <u>Kerby Deaton</u>
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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.	17. INFORMANT Address <u>Kerby Deaton Rosendale mo</u>
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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>Acute Renal Insufficiency</u>	INTERVAL BETWEEN ONSET AND DEATH <u>6 days</u>
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Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <u>Carcinoma of Rectum with Metastasis to Vagina & Urethra</u>	INTERVAL BETWEEN ONSET AND DEATH <u>8 mo.</u>
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PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>154X</u>	19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
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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.)
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20c. TIME OF INJURY Hour Month, Day, Year a.m. p.m.	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
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21. I attended the deceased from <u>13 Dec 58</u> to <u>5 JAN 59</u> and last saw her/him alive on <u>5 JAN 59</u> Death occurred at <u>3:45 p.</u> m on the date stated above; and to the best of my knowledge, from the causes stated.

22a. SIGNATURE <u>[Signature]</u>	22b. ADDRESS <u>706 Francis St. Joseph mo</u>	22c. DATE SIGNED <u>7 JAN 59</u>
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23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>	23b. DATE <u>1-7-1959</u>	23c. NAME OF CEMETERY OR CREMATORY <u>SAVANNAH</u>	23d. LOCATION (City, town, or county) (State) <u>SAVANNAH mo</u>
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24. FUNERAL DIRECTOR ADDRESS <u>Breit Funeral Home SAVANNAH mo</u>	25. DATE RECD. BY LOCAL REG. <u>Jan 8, 1959</u>	26. REGISTRAR'S SIGNATURE <u>Mrs Clark Goodell</u>
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vector, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed. All diseases in Part I must be causally related.

Dr. John N. Martin
MEDICAL CERTIFICATION
USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

AUG 24 1959

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 *James P. Hawkins*
Licensed Embalmer No. *4536*

P. O. Address *Savannah*

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.