

Health,  
& Welfare  
Public  
Service

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

59-000415  
STATE FILE NUMBER

FILED JAN 23 1959  
XC-203616

REG # A44

Registration District No. 43 Primary Registration District No. 3007 Registrar's No. 19

300  
1-57

1. PLACE OF DEATH a. COUNTY <b>BUTLER</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MISSOURI</b> b. COUNTY <b>DUNKLIN</b>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>POPLAR BLUFF</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <b>SENATH</b> 6356 Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (IF NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>VETERANS ADM. HOSPITAL</b>		Length of stay in lb <b>1 DAY</b>	d. STREET ADDRESS (If outside, give location) <b>NONE</b> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print) First <b>WILLIAM</b> Middle <b>BRYAN</b> Last <b>REVELLE</b>			4. DATE OF DEATH Month <b>JANUARY</b> Day <b>8</b> Year <b>1959</b>		
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5. SEX <b>MALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> 2. DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>7-6-97</b>	9. AGE (In years last birthday) <b>61</b>	IF UNDER 1 YEAR Months Days	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) <b>SEAMAN</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>SAILOR</b>	11. BIRTHPLACE (City and state or country) <b>DONGALA, MISSOURI</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>
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13a. FATHER'S NAME <b>FRANK REVELLE</b>		13b. MOTHER'S MAIDEN NAME <b>SARAH HILL</b>		14. NAME OF HUSBAND OR WIFE <b>DECEASED</b>	
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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) <b>YES WWI</b>		16. SOCIAL SECURITY NO. <b>070169319</b>	17. INFORMANT Address <b>VA HOSPITAL RECORDS, POPLAR BLUFF, MO.</b>		
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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) <b>PERITONITIS, ACUTE, GENERALIZED.</b>				INTERVAL BETWEEN ONSET AND DEATH <b>1 Day.</b>	
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) <b>PERFORATION, ULCERATIVE, SIGMOID, ACUTE.</b>	DUE TO (c) <b>DIVERTICULITIS, SIGMOID, ACUTE.</b>	19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <b>1. DIVERTICULOSIS, CONGENITAL. 2. DIABETES MELLITUS</b>	<b>5721</b>				

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 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		
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21. I attended the deceased from <b>Jan. 7, 1959</b> to <b>Jan. 8, 1959</b> Death occurred at <b>3:50 A.M.</b> m on the date stated above; and to the best of my knowledge, from the causes stated.					
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22a. SIGNATURE <b>J. LESTER HARWELL, M.D., Actg. Pathologist</b>				22b. ADDRESS <b>VA HOSPITAL, POPLAR BLUFF, MO.</b>		22c. DATE SIGNED <b>1/8/59</b>	
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23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		23b. DATE <b>1/10/59</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Senath</b>		23d. LOCATION (City, town, or county) (State) <b>Senath, Missouri</b>		
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24. FUNERAL DIRECTOR <b>McDaniel</b>		ADDRESS <b>Senath, Missouri</b>		25. DATE RECD. BY LOCAL REG. <b>1/17/59</b>		26. REGISTRAR'S SIGNATURE <i>[Signature]</i>	
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USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE  
MEDICAL CERTIFICATION  
Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed.  
All diseases in Part I must be causally related.

FILE NO. \_\_\_\_\_  
JULIEN CO. HEALTH CENTER

FEB 26 1959

FEB 24 1959

FEB 18 1959

SEP 1 1958

JAN 26 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 Hubert B. Baird

Licensed Embalmer No. 4888  
P. O. Address, Kenneth M

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.