Health, & Welfare Public Service

300
1-57

THE DIVISION OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

59-001156
STATE FILE NUMBER

FILED FEB 2 1959 Registration District No. 142 Primary Registration District No. 5336 Registrar's No. 11

1. PLACE OF DEATH
a. COUNTY HOWELL
b. CITY OR TOWN (If outside corporate limits, give TOWNSHIP only) MT. VIEW, MO. Inside Limits Yes [X] No [ ]
c. FULL NAME OF HOSPITAL OR INSTITUTION (If NOT in hospital, give location) ST. FRANCIS Length of stay in Hospital 30 Min

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE MO. b. COUNTY OREGON
c. CITY OR TOWN ROVER 0759 Inside Limits Yes [ ] No [ ]
d. STREET ADDRESS (If outside, give location) Rt 1 Kashkonong Reside on Farm Yes [X] No [ ]

3. NAME OF DECEASED (Type or print) First TAMMY Middle SUE Last JETT
4. DATE OF DEATH Month JAN Day 7 Year 59
5. SEX F
6. COLOR OR RACE W
7. MARRIED [ ] NEVER MARRIED [X] WIDOWED [ ] DIVORCED [ ]
8. DATE OF BIRTH Jan 7, 1959
9. AGE (In years last birthday) IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours 30 Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
10b. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (City and state or country) MT. VIEW, MO.
12. CITIZEN OF WHAT COUNTRY? USA
13a. FATHER'S NAME SAM JETT
13b. MOTHER'S MAIDEN NAME SHIRLEY JUDD
14. NAME OF HUSBAND OR WIFE NONE
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.
17. INFORMANT SAM JETT Address RT 1 KOSHKONONG, MO.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) INTERVAL BETWEEN ONSET AND DEATH
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Cerebral Hemorrhage
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) Cephalo-pelvic disproportion
DUE TO (c)
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) 7600
19. WAS AUTOPSY PERFORMED? YES [ ] NO [ ]
20a. ACCIDENT [ ] SUICIDE [ ] HOMICIDE [ ]
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 [ ] NOT WHILE AT WORK [ ]
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 1/7/59 to 1/7/59 and last saw her/him alive on 1/7/59
Death occurred at 6:32 A m on the date stated above; and to the best of my knowledge, from the causes stated.
22a. SIGNATURE (Degree or title) [illegible] M. D.
22b. ADDRESS West Plains, Missouri
22c. DATE SIGNED 1/16/59
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL
23b. DATE 1-8-1959
23c. NAME OF CEMETERY OR CREMATORY REDBURN CEMETERY
23d. LOCATION (City, town, or county) (State) ROVER, MO.
24. FUNERAL DIRECTOR ROBERTSONS ADDRESS WEST PLAINS, MO.
25. DATE RECD. BY LOCAL REG. 1-29-59
26. REGISTRAR'S SIGNATURE Laura Mitchell

(Licensed Embalmer's Statement on Reverse Side)

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

All diseases in Part I must be causally related.

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 .....

Licensed Embalmer No. 4597

P. O. Address .....

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.