

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

59-001766
STATE FILE NUMBER

FILED FEB 11 1959 Registration District No. 157 Primary Registration District No. 3028 Registrar's No. 36

300
1-57

1. PLACE OF DEATH a. COUNTY Jasper		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY Jasper	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Carthage		c. CITY OR TOWN Carthage	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION McCune-Brooks		d. STREET ADDRESS (If outside, give location) 520 Pine St.	
3. NAME OF DECEASED First Middle Last WILLIE FRANCES RORICK		4. DATE OF DEATH Month Day Year Feb 2, 1959	
5. SEX female	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> 2 DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH April 25, 1859
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) retired housewife		10b. KIND OF BUSINESS OR INDUSTRY domestic	11. BIRTHPLACE (City and state or country) Lawrence Co, Mo
13a. FATHER'S NAME unknown		13b. MOTHER'S MAIDEN NAME unknown	14. NAME OF HUSBAND OR WIFE John B. Rorick
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, or unknown) (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO. none	17. INFORMANT Address Jed E. Brown, 135 S. Main, Carthage, Mo
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hypostatic pneumonia Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) Laceration left lung & pneumothorax DUE TO (c) Fractured left ribs 9040			INTERVAL BETWEEN ONSET AND DEATH 12 hrs 5 days 5 day
20a. ACCIDENT <input checked="" 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.) Fall in bathroom at home	
20c. TIME OF INJURY Hour Month, Day, Year 2:00 p.m. 1-27-59		20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE WORK <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) home		20f. CITY, TOWN, OR LOCATION COUNTY STATE Carthage Jasper Mo	
21. I attended the deceased from 12-30-47 to 2-2-59 and last saw her alive on 2-2-59 Death occurred at 10 a m on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE M. Foster Whitten M.D.		22b. ADDRESS MO 22c. DATE SIGNED 616 W. Centennial, Carthage, 2-2-59	
23a. BURIAL, CREMATION, REMOVAL (Specify) burial		23b. DATE 2-4-59	
23c. NAME OF CEMETERY OR CREMATORY Park Cemetery		23d. LOCATION (City, town, or county) (State) Carthage, Mo	
24. FUNERAL DIRECTOR KNELL MORTUARY		25. DATE RECD. BY LOCAL REG. 2-4-59	
26. REGISTRAR'S SIGNATURE		Ely Clifton	

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.

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 *D. L. Isbell*

Licensed Embalmer No. *4970*
P. O. Address *Carthage, 7*

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.