

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

59-001943
STATE FILE NUMBER

FILED JAN 19 1959 Registration District No. 175 Primary Registration District No. 3036 Registrar's No. 6

1. PLACE OF DEATH a. COUNTY <u>Lawrence</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Lawrence</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Aurora</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <u>Aurora</u> <u>6551</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>142 E. Spfd. St.</u>		Length of stay in lb <u>2 Years</u>	d. STREET ADDRESS (If outside, give location) <u>142 E. Springfield</u> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <u>MARY</u> Middle <u>MOLLY</u> Last <u>TOLLE</u>			4. DATE OF DEATH Month <u>Jan.</u> Day <u>12</u> Year <u>1959</u>
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Sept. 25 1869</u>
9. AGE (In years last birthday) <u>89</u>		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) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Home</u>	11. BIRTHPLACE (City and state or country) <u>Missouri</u>
12. CITIZEN OF WHAT COUNTRY? <u>USA.</u>		13a. FATHER'S NAME <u>James Pallett</u>	
13b. MOTHER'S MAIDEN NAME <u>Sarah Teague</u>		14. NAME OF HUSBAND OR WIFE - - - - -	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. - - - - -	
17. INFORMANT <u>Mrs. Orpha Garen Billings, Mo.</u>		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) <u>Myocardial Infarction</u> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. } DUE TO (b) <u>Generalized A.S.</u> DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>4201</u>			INTERVAL BETWEEN ONSET AND DEATH <u>1 day</u>
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 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 <u>Aurora, Mo.</u>		COUNTY _____ STATE _____	
21. I attended the deceased from <u>6/5/58</u> to <u>1/12/59</u> and last saw ^{her} _{him} alive on <u>1/12/59</u> Death occurred at <u>2:45</u> p.m. on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE <u>Dr. Maurice M.D.C.</u> (Degree or title)		22b. ADDRESS <u>Aurora, Mo.</u>	
22c. DATE SIGNED <u>1/15/59</u>		22d. DATE SIGNED <u>1/15/59</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE <u>1/15/59</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Smart Cemetery</u>		23d. LOCATION (City, town, or county) (State) <u>Billings, Mo.</u>	
24. FUNERAL DIRECTOR <u>Arnold's Funeral Home;</u> ADDRESS <u>Aurora, Mo.</u>		25. DATE RECD. BY LOCAL REG. <u>1/15/59</u>	
26. REGISTRAR'S SIGNATURE <u>Orva Mc Natt</u>			

All diseases in Part I must be causally related.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

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 *Arvin Q. Arnold*

Licensed Embalmer No. *4929*

P. O. Address *Altoona, Pa.*

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.