8

THE DIVISION OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

59-002050
STATE FILE NUMBER

FILED FEB 2 1959 Registration District No. 187 Primary Registration District No. 3040 Registrar's No. 28

1. PLACE OF DEATH a. COUNTY Livingston	2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY Livingston
b. CITY OR TOWN (If outside corporate limits, give TOWNSHIP only) Chillicothe — Inside Limits Yes [X] No [ ]	c. CITY OR TOWN Chula 0598 — Inside Limits Yes [X] No [ ]
c. FULL NAME OF HOSPITAL OR INSTITUTION (If NOT in hospital, give location) City hospital — Length of stay in 1b 2½ yrs.	d. STREET ADDRESS (If outside, give location) No street address — Reside on Farm Yes [ ] No [X]

3. NAME OF DECEASED (Type or print): First Rosa, Middle Helen, Last Wasson

4. DATE OF DEATH: Month Jan. Day 23, Year 1959

5. SEX: Fem. Ale

6. COLOR OR RACE: White

7. MARRIED [ ] NEVER MARRIED [ ] WIDOWED [X] 2 DIVORCED [ ]

8. DATE OF BIRTH: Mar. 8, 1878

9. AGE (In years last birthday): 80 — 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): Housewife

10b. KIND OF BUSINESS OR INDUSTRY: Own home

11. BIRTHPLACE (City and state or country): Livingston Co., Mo. 0

12. CITIZEN OF WHAT COUNTRY? USA

13a. FATHER'S NAME: John F. Mills

13b. MOTHER'S MAIDEN NAME: Fanny Guthrie

14. NAME OF HUSBAND OR WIFE: William (dec)

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no (If yes, give war or dates of service) XX

16. SOCIAL SECURITY NO.: None

17. INFORMANT: Mrs. W. C. Marcum, Address: Berwyn, Ill.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) Myocardial Failure — INTERVAL BETWEEN ONSET AND DEATH

Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) Fract of Left Hip. — 5 days

DUE TO (c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)

19. WAS AUTOPSY PERFORMED? YES [ ] NO [ ] 0

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

0 59

21. I attended the deceased from 1948, to 23 Jan 59 and last saw her/him alive on 23 Jan 59

Death occurred at 11:15 A m on the date stated above; and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title): V D Vandina M.D.

22b. ADDRESS: Chillicothe Mo

22c. DATE SIGNED: 24 Jan 59

23a. BURIAL, CREMATION, REMOVAL (Specify): burial

23b. DATE: Jan. 26, 1959

23c. NAME OF CEMETERY OR CREMATORY: Edgewood cemetery

23d. LOCATION (City, town, or county) (State): Chillicothe, Mo.

24. FUNERAL DIRECTOR — ADDRESS: Donald Gordon, Chillicothe, Mo.

25. DATE RECD. BY LOCAL REG.: 1-24-59

26. REGISTRAR'S SIGNATURE: Frances B Neill

(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 Richard H. Randall

Licensed Embalmer No. 4866

P. O. Address Chillicothe

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.