Health, Welfare Public Service

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1-57

THE DIVISION OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

59-002388
STATE FILE NUMBER

FILED JAN 12 1959 Registration District No. 274 Primary Registration District No. 3052 Registrar's No. 8

1. PLACE OF DEATH a. COUNTY Pettis
b. CITY OR TOWN Sedalia Inside Limits Yes ☒ No ☐
c. FULL NAME OF HOSPITAL OR INSTITUTION (If NOT in hospital, give location) 309 E. Jefferson Length of stay in 1b

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Mo b. COUNTY Pettis
c. CITY OR TOWN Sedalia Inside Limits Yes ☒ No ☐
d. STREET ADDRESS (If outside, give location) 309 E Jefferson Reside on Farm Yes ☒ No ☐

3. NAME OF DECEASED (Type or print) First Ophelia Middle M. Last Washington
4. DATE OF DEATH Month 1 Day 1 Year 1959
5. SEX Female
6. COLOR OR RACE Negro
7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH 7-19-1954
9. AGE (In years last birthday) 4 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)
10b. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (City and state or country) Sedalia Pettis Mo
12. CITIZEN OF WHAT COUNTRY? U. S. A.
13a. FATHER'S NAME Unknown
13b. MOTHER'S MAIDEN NAME Ophelia Washington
14. NAME OF HUSBAND OR WIFE
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 Ophelia Washington Address Sedalia

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

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) Bronchial pneumonia
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b)
DUE TO (c)
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) Muscular dystrophy 491X
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~~ viewed the deceased from as Corner and last ~~saw~~ her/him alive on
Death occurred at 9:00 am on the date stated above; and to the best of my knowledge, from the causes stated.

22a. SIGNATURE Chas Gordon Stempfle (Degree or title) M.D.
22b. ADDRESS Corner Ozarks Co
22c. DATE SIGNED 1-2-59

23a. BURIAL, CREMATION, REMOVAL (Specify) Buried
23b. DATE 1-5-59
23c. NAME OF CEMETERY OR CREMATORY Crown Hill Annex
23d. LOCATION (City, town, or county) Sedalia Pettis (State) Mo

24. FUNERAL DIRECTOR George T. Green ADDRESS Marshall Mo
25. DATE RECD. BY LOCAL REG. Jan 5, 1959
26. REGISTRAR'S SIGNATURE Frances Shelby

(Licensed Embalmer's Statement on Reverse Side)

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 George H. Green

1-59

Licensed Embalmer No. 4220

P. O. Address Marshall Mo

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.