

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

59-004169  
STATE FILE NUMBER

FILED FEB 3 1959 Registration District No. 381 Primary Registration District No. 6183 Registrar's No. 10

300  
1-57

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.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE  
MEDICAL CERTIFICATION

1. PLACE OF DEATH a. COUNTY <b>Sullivan</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Missouri</b> b. COUNTY <b>Sullivan</b>					
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>Milan</b>		Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>		c. CITY OR TOWN <b>Green City</b> 1050		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>			
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>Fraizer Rest Home</b>			Length of stay in 1b		d. STREET ADDRESS (If outside, give location)		Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First <b>Edgar</b> Middle <b>Ellsworth</b> Last <b>Custer</b>				4. DATE OF DEATH Month <b>1</b> Day <b>23</b> Year <b>59</b>					
5. SEX <b>M</b> <b>C</b> <b>W</b>		6. COLOR OR RACE <b>W</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>Sept 5 1863</b>		9. AGE (In years last birthday) IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days 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) <b>Wisconsin</b>		12. CITIZEN OF WHAT COUNTRY? <b>1</b>		
13a. FATHER'S NAME <b>William K. Custer</b>			13b. MOTHER'S MAIDEN NAME <b>Isabel Jane Newcomb.</b>			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 <b>Daisy Newcomb - Green City Mo</b> 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) <b>Coronary Thrombosis</b> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <b>Hypertension</b> DUE TO (c) <b>Senile change</b>							INTERVAL BETWEEN ONSET AND DEATH <b>instant</b>		
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 <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 <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		COUNTY		STATE	
21. I attended the deceased from <b>12-58</b> to <b>1-23-59</b> and last saw <sup>her</sup> him alive on <b>1-21-59</b> Death occurred at <b>12:30 P</b> m on the date stated above; and to the best of my knowledge, from the causes stated.									
22a. SIGNATURE <b>E. W. Simpson D.O.</b> (Degree or title)					22b. ADDRESS <b>Milan</b>			22c. DATE SIGNED <b>1-24-59</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY <b>Cremation</b>			23d. LOCATION (City, town, or county) (State) <b>Kansas City Mo.</b>		
24. FUNERAL DIRECTOR <b>Wade Funeral Home</b> ADDRESS <b>Browning, Mo</b>			25. DATE RECD. BY LOCAL REG. <b>1-28-59</b>		26. REGISTRAR'S SIGNATURE <b>mo. m. w. Beckett</b>				

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 *Serald T. ...*

Licensed Embalmer No. *4173*

P. O. Address *Brown*

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.