THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

59-004325
STATE FILE NUMBER

FILED MAR 9 1959 Registration District No. 1 Primary Registration District No. 3000 Registrar's No. 70

1. PLACE OF DEATH
a. COUNTY Adair
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Kirksville — Inside Limits Yes [X] No [ ]
c. FULL NAME OF HOSPITAL OR INSTITUTION (If NOT in hospital, give location) K. O. H. — Length of stay in lb 14 yrs

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Missouri b. COUNTY Adair
c. CITY OR TOWN Kirksville — Inside Limits Yes [X] No [ ]
d. STREET ADDRESS (If outside, give location) 1221 N. Main — Reside on Farm Yes [ ] No [X]

3. NAME OF DECEASED (Type or print) First MYLINDA Middle JANE Last ALLRED
4. DATE OF DEATH Month Day Year Feb. 25 1959
5. SEX Female
6. COLOR OR RACE White
7. MARRIED [X] NEVER MARRIED [ ] WIDOWED [X] 2 DIVORCED [X]
8. DATE OF BIRTH Aug. 4 1865
9. AGE (In years last birthday) 93 — 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) Homemaker
10b. KIND OF BUSINESS OR INDUSTRY own home
11. BIRTHPLACE (City and state or country) Cole Co. Illinois
12. CITIZEN OF WHAT COUNTRY? U S
13. FATHER'S NAME William Jackson Jennings
14. MOTHER'S MAIDEN NAME Nancy Jane Watson
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service) No
16. SOCIAL SECURITY NO. No
17. INFORMANT Address W.L. Allred, Kirkville, Mo.

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) pneumonia lobar — INTERVAL BETWEEN ONSET AND DEATH 1 month
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) Inanition 490X
19. WAS AUTOPSY PERFORMED? YES [ ] NO [X] 2.
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 the deceased from Feb 21, to Feb 25, 1959 and last saw her alive on Feb 25
Death occurred at 11:30 pm m on the date stated above; and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) M T Gutensohn D.O. 2
22b. ADDRESS Kirksville Mo
22c. DATE SIGNED 2-25-59

23a. BURIAL, CREMATION, REMOVAL (Specify) Burial
23b DATE Feb. 28/59
23c. NAME OF CEMETERY OR CREMATORY Hall
23d. LOCATION (City, town, or county) (State) Adair, Co. Mo.

24. FUNERAL DIRECTOR Joseph E. Foster ADDRESS Kirksville, Mo.
25. DATE RECD. BY LOCAL REG. 2-28-1959
26. REGISTRAR'S SIGNATURE Doris W. Ratliff

(Licensed Embalmer's Statement on Reverse Side)

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE
Dr. Gutensohn
M.T. Gutensohn, D.O.
diseases in Part I must be casually related. Coroner cannot certify to a death due to natural causes.

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was e

by me, or by ....., Student Embalmer No.....

working under my personal supervision..

Student.....
Signature of Student Embalmer

Signed Nova E. Foster

Nova E. Foster
Licensed Embalmer No. 47

P. O. Address
Kirksville, Mo.

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING.
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.