

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

59-004404

STATE FILE NUMBER

FILED MAR 16 1959

Registration District No. 10 Primary Registration District No. 5036 Registrar's No. 58

S. 300
1-57

All diseases in Part I must be causally related.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

1. PLACE OF DEATH a. COUNTY <u>Andrain</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Andrain</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Centralia, Wilson</u>		Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	c. CITY OR TOWN <u>Centralia 2046</u>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>R. F. D. # 1</u>		Length of stay in 1b <u>67 years</u>	d. STREET ADDRESS (If outside, give location) <u>R. F. D. # 1</u>
3. NAME OF DECEASED (Type or print) First <u>James</u> Middle <u>Oliver</u> Last <u>Sims</u>			4. DATE OF DEATH Month <u>Mar.</u> Day <u>6</u> Year <u>1959</u>
5. SEX <u>Male</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. 7 - 1865</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farming</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Farming</u>	9. AGE (In years last birthday) <u>93</u>
11a. FATHER'S NAME <u>O. B. Sims</u>		11b. MOTHER'S MAIDEN NAME <u>Francis Maxwell</u>	11c. NAME OF HUSBAND OR WIFE <u>deceased</u>
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) <u>NO</u>		16. SOCIAL SECURITY NO. <u>489-42-9420</u>	17. INFORMANT Address <u>MRS. Elsie Dickey, Centralia, Mo.</u>
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>Coronary thrombosis</u>			INTERVAL BETWEEN ONSET AND DEATH <u>Sudden</u>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <u>Arteriosclerosis</u>			Duration <u>unknown</u>
DUE TO (c) <u>---</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>---</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.) <u>4201</u>	
20c. TIME OF INJURY Hour Month, Day, Year a.m. p.m.		20d. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <u>---</u>	
20e. INJURY OCCURRED WHILE AT <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		20f. CITY, TOWN, OR LOCATION COUNTY STATE	
21. I attended the deceased from <u>September 22, 1945</u> to <u>Mar. 6, 1959</u> and last saw him alive on <u>Dec. 15, 1958</u> Death occurred at <u>3/6/59</u> <u>9:00 P</u> on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree or title) <u>L. Lachance, M. D. L. Lachance, M.D.</u>		22b. ADDRESS <u>Centralia, Missouri</u>	
22c. DATE SIGNED <u>3/7/59</u>			
23a. BURIAL (CREMATION) REMOVAL (Specify) <u>Burial</u>	23b. DATE <u>Mar. 9-1959</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Salt River Cemetery</u>	23d. LOCATION (City, town, or county) (State) <u>Andrain County, Mo.</u>
24. FUNERAL DIRECTOR <u>Paul J. Ballou, Centralia, Mo.</u>		25. DATE RECD. BY LOCAL REG. <u>March 9-1959</u>	26. REGISTRAR'S SIGNATURE <u>Blanche Neely</u>

MS
MAR 18 1958

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 *Lane J. Ballou*

Licensed Embalmer No. *4206*

P. O. Address *Centradia, Md*

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.