Health, & Welfare Public Service

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THE DIVISION OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

59-004704
STATE FILE NUMBER

FILED FEB 16 1959 Registration District No. 47 Primary Registration District No. 3008 Registrar's No. 47

1. PLACE OF DEATH
a. COUNTY Callaway
b. CITY OR TOWN (If outside corporate limits, give TOWNSHIP only) Fulton — Inside Limits Yes ☑ No ☐
c. FULL NAME OF HOSPITAL OR INSTITUTION (If NOT in hospital, give location) State Hosp #1 — Length of stay in ☐ 4 months

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Mo. b. COUNTY Howard
c. CITY OR TOWN Armstrong 0450 Mo — Inside Limits Yes ☐ No ☐
d. STREET ADDRESS (If outside, give location) — Reside on Farm Yes ☐ No ☐

3. NAME OF DECEASED (Type or print) First Jesse Middle M. Last Magouder
4. DATE OF DEATH Month 2 Day 8 Year 59

5. SEX Male
6. COLOR OR RACE White
7. MARRIED ☑ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH 1-27-1880
9. AGE (In years last birthday) 77 — 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) Retired
10b. KIND OF BUSINESS OR INDUSTRY DK.
11. BIRTHPLACE (City and State or country) Howard Co Mo
12. CITIZEN OF WHAT COUNTRY?

13a. FATHER'S NAME William Magouder
13b. MOTHER'S MAIDEN NAME Martha Ware
14. NAME OF HUSBAND OR WIFE Effie Magouder

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) DK
16. SOCIAL SECURITY NO. DK
17. INFORMANT Hosp. Recd. Address Fulton 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) Bronchial pneumonitis
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. ~~DUE TO~~ (b) Chronic Bronchitis
DUE TO (c) Diffuse myocardial arteriosclerotic heart disease
INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) Herpes Zoster - n. face
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.) 4221
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 Sept. 29, 1958, to Feb. 8, 1959 and last saw her/him alive on Feb. 8, 1959
Death occurred at 6 PM m on the date stated above; and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) Wm J. Cremer M.D.
22b. ADDRESS State Hosp #1 Fulton
22c. DATE SIGNED 2-8-59

23a. BURIAL, CREMATION, REMOVAL (Specify) Removal
23b. DATE Feb. 8-1959
23c. NAME OF CEMETERY OR CREMATORY DK.
23d. LOCATION (City, town, or county) Lancaster (State) Mo

24. FUNERAL DIRECTOR Wallace Funeral Home ADDRESS Fulton Mo
25. DATE RECD. BY LOCAL REG. Feb. 8-1959
26. REGISTRAR'S SIGNATURE Maretta Lawrence

(Licensed Embalmer's Statement on Reverse Side)

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

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 H. B. Masure .....

Licensed Embalmer No. 4996

P. O. Address Fulton, 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.