Health, Welfare Public Service

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THE DIVISION OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

59-004710
STATE FILE NUMBER

Registration District No. 47 Primary Registration District No. 3008 Registrar's No. 51

1. PLACE OF DEATH a. COUNTY CALLAWAY	2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY Jackson
b. CITY OR TOWN (If outside corporate limits, give TOWNSHIP only) FULTON — Inside Limits Yes [X] No [ ]	c. CITY OR TOWN Kansas City 3274 — Inside Limits Yes [X] No [ ]
c. FULL NAME OF HOSPITAL OR INSTITUTION (If NOT in hospital, give location) STATE HOSPITAL #1 — Length of stay in 1b 12yrs.8mos.	d. STREET ADDRESS (If outside, give location) 810 East 15th Street — Reside on Farm Yes [ ] No [ ]

3. NAME OF DECEASED (Type or print) First: EDWARD	Middle: LESTER	Last: SIMS	4. DATE OF DEATH Month Day Year: February 12, 1959
5. SEX: Male	6. COLOR OR RACE: White	7. MARRIED [ ] NEVER MARRIED [X] WIDOWED [ ] DIVORCED [ ]	8. DATE OF BIRTH: January 25, 1896
9. AGE (In years last birthday): 63	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): Cook	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and state or country): Nebraska	12. CITIZEN OF WHAT COUNTRY? U.S.A.
13a. FATHER'S NAME: Henry Sims	13b. MOTHER'S MAIDEN NAME: Elizabeth ??	14. NAME OF HUSBAND OR WIFE: None	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service): unk.	16. SOCIAL SECURITY NO.: unk.	17. INFORMANT Address: State Hospital No. 1; Fulton, Missouri	

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) CORONARY EMBOLISM — INTERVAL BETWEEN ONSET AND DEATH

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) 4201

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. Attended the deceased from 6-21-46, to 2-12-59 ~~[illegible]~~ Sty Hosp. #1

Death occurred at 12:15 p.m. m on the date stated above; and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title): R. C. Robuhn	22b. ADDRESS: State Hospital #1; Fulton, Mo.	22c. DATE SIGNED: 2-12-59
23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE: 2-13-59	23c. NAME OF CEMETERY OR CREMATORY: anatomical Board
23d. LOCATION (City, town, or county): Columbia (State): mo		
24. FUNERAL DIRECTOR: J. O. Roberts ADDRESS: Columbia mo	25. DATE RECD. BY LOCAL REG.: Feb. 13-1959	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 ..... Signed .....
Signature of Student Embalmer

Licensed Embalmer No. .....

P. O. Address .....

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.