

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

59-006224

STATE FILE NUMBER

FILED FEB 24 1959

Registration District No. 174 Primary Registration District No. 370 35 Registrar's No. 12

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-57

1. PLACE OF DEATH a. COUNTY <u>Lafayette</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Lafayette</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Lexington</u>	Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <u>Lexington</u>	Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>130 N. 10 St.</u>	Length of stay in lb <u>50yrs</u>	d. STREET ADDRESS <u>130. No 10 St</u>	Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print) <u>Howard</u>	First	Middle	Last	4. DATE OF DEATH <u>January 25, 1959</u>	Month	Day	Year
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5. SEX <u>Male</u>	6. COLOR OR RACE <u>Negro</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>June 14, 1884</u>	9. AGE (In years last birthday) <u>75</u>	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours	Min.
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10a. USUAL OCCUPATION (Give kind of work done during preceding life, even if retired) <u>employee</u>	10b. KIND OF BUSINESS OR INDUSTRY <u>labor</u>	11. BIRTHPLACE (City and state or country) <u>Lexington, Mo</u>	12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>
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13a. FATHER'S NAME <u>Henry Harden</u>	13b. MOTHER'S MAIDEN NAME <u>Julia Mayberry</u>	14. NAME OF HUSBAND OR WIFE <u>none</u>
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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>none</u>	17. INFORMANT <u>Raymond Hardin</u>	Address <u>Lexington Mo.</u>
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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>Cerebral hemorrhage</u> DUE TO (b) <u>generalized arteriosclerosis</u> DUE TO (c) <u>Malnutrition</u>	INTERVAL BETWEEN ONSET AND DEATH <u>6 days</u>
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PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>Malnutrition</u>	19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
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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.)
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20c. TIME OF INJURY Hour a.m. p.m.	20d. INJURY OCCURRED WHILE AT WORK <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
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21. I attended the deceased from Death occurred at <u>Jan 19 1959</u> to <u>Jan 25 1959</u> <u>9:30</u> p.m. on the date stated above; and to the best of my knowledge, from the causes stated.	21. I attended the deceased from Death occurred at <u>Jan 19 1959</u> to <u>Jan 25 1959</u> <u>9:30</u> p.m. on the date stated above; and to the best of my knowledge, from the causes stated.	21. I attended the deceased from Death occurred at <u>Jan 19 1959</u> to <u>Jan 25 1959</u> <u>9:30</u> p.m. on the date stated above; and to the best of my knowledge, from the causes stated.
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22a. SIGNATURE (Degree or title) <u>Ralph W. Riley M.D.</u>	22b. ADDRESS <u>Lexington</u>	22c. DATE SIGNED <u>1-30-59</u>
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23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE <u>Jan. 30, 1959</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Forest Grove Cemetery</u>	23d. LOCATION (City, town, or county) <u>Lexington</u>	(State) <u>Mo.</u>
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24. FUNERAL DIRECTOR <u>George H. Green</u>	ADDRESS <u>Marshall, Mo</u>	25. DATE RECD. BY LOCAL REG. <u>2-10-59</u>	26. REGISTRAR'S SIGNATURE <u>Wm. E. Eastbrook</u>
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USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

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 *Georgette Gunn*

Licensed Embalmer No. *4220*

P. O. Address *Richhill 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.