

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

59-006317

STATE FILE NUMBER

FILED MAR 13 1959

Registration District No. 187 Primary Registration District No. 3040 Registrar's No. 67

1. PLACE OF DEATH a. COUNTY <u>Livingston</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Carroll</u>				
b. CITY (If outside corporate limits, give TOWNSHIP or TOWN) <u>Chillicothe</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		c. CITY OR TOWN <u>Tina RFD</u>		Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>		
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>Chillicothe Hospital</u>				Length of stay in 1b <u>2 weeks</u>		d. STREET ADDRESS (If outside, give location) <u>4 M. N/W</u>		
3. NAME OF DECEASED (Type or print) First <u>ALBERT</u> Middle <u>BENTON</u> Last <u>DRAWBAUGH</u>				4. DATE OF DEATH Month <u>Feb.</u> Day <u>13th</u> Year <u>1959</u>				
5. SEX <u>M</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Aug. 21st, 1883</u>		9. AGE (In years last birthday) <u>75</u>	IF UNDER 1 YEAR Month <u>5</u> Days <u>22</u> Hours <u></u> Min. <u></u>	IF UNDER 24 HRS. Hours <u></u> Min. <u></u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired Farmer</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>Livestock-Grain</u>		11. BIRTHPLACE (City and state or country) <u>Lenox, Iowa</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Armstrong Drawbaugh</u>				14. MOTHER'S MAIDEN NAME <u>Sarah Grissinger</u>				
15. WAS DECEASED EVER IN U. S. ARMED SERVICES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u> <u>No</u>		16. SOCIAL SECURITY NO. <u>494-40-8161</u>		17. INFORMANT <u>Mrs Lillian L. Drawbaugh, Tina, Mo.</u> Address				
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>Pneumonia Terminal</u> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <u>Asthma Severe</u> DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____							INTERVAL BETWEEN ONSET AND DEATH <u>24 hrs</u> <u>2 yrs</u>	
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>241X</u>					
20c. TIME OF INJURY Hour _____ a. m. _____ p. m. Month, Day, Year _____								
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 _____		
21. I attended the deceased from <u>Jan 1-58</u> to <u>Feb. 13-59</u> and last saw her alive on <u>Feb-12-59</u> Death occurred at <u>5:30 A.M.</u> m on the date stated above; and to the best of my knowledge, from the causes stated.								
22a. SIGNATURE (Degree or title) <u>Joseph P. Conrad M.D.</u>				22b. ADDRESS <u>Chillicothe Mo</u>		22c. DATE SIGNED <u>Nov-5-59</u>		
23a. BURIAL, CREATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE <u>2/15/1959</u>	23c. NAME OF CEMETERY OR CREMATORY <u>ARKADELPHIA.</u>		23d. LOCATION (City, town, or county) (State) <u>Avalon, Missouri</u>			
24. FUNERAL DIRECTOR ADDRESS <u>Clifford W. Austin Tina, Mo.</u>				25. DATE RECD. BY LOCAL REG. <u>march-12-59</u>		26. REGISTRAR'S SIGNATURE <u>Frances B Neill</u>		

(Licensed Embalmer's Statement on Reverse Side)

300  
1-56

diseases in Part I must be casually related. Coroner cannot certify to a death due to natural causes.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

MAR 28 1958

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was examined by me, or by ....., Student Embalmer No. .... working under my personal supervision..

Student.....  
Signature of Student Embalmer

Signed *Clifford W. Austin*

Licensed Embalmer No. #32

P. O. Address Tina, Miss

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.