

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

59-006463

Health,
Welfare
Public
Service

FILED MAR 11 1959 Registration District No. 236 Primary Registration District No. 4352 STATE FILE NUMBER Registrar's No. 10

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|---|--|---|--|
| 1. PLACE OF DEATH a. COUNTY MORGAN | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY MORGAN | |
| b. CITY (If outside corporate limits give TOWNSHIP only) OR TOWN Versailles | | Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> | c. CITY OR TOWN Versailles 0710 Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> |
| c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Kidwell - Nurs. Ng. Home - 2 yrs | | Length of stay in 1b | d. STREET ADDRESS (If outside, give location) Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> |

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|--|----------------------------------|---|--|--|---|
| 3. NAME OF DECEASED (Type or print) First Luella Middle Last Dearolph | | | 4. DATE OF DEATH Month MARCH Day 4 Year 1959 | | |
| 5. SEX Female | 6. COLOR OR RACE White | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> 2 DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH 11 April - 1891 | | 9. AGE (In years last birthday) 67 |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House - wife | | 10b. KIND OF BUSINESS OR INDUSTRY At - Home | 11. BIRTHPLACE (City and state or county) MORGAN - Co - Mo | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. |

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|--|--|--|--|---|--|
| 13a. FATHER'S NAME William - Anderson | | 13b. MOTHER'S MAIDEN NAME Nancy - Kelsay | | 14. NAME OF HUSBAND OR WIFE Finland - Dearolph | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No | | 16. SOCIAL SECURITY NO. None | | 17. INFORMANT Address William - A - Pettigrew - Versailles Mo | |

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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) Cerebrovascular accident | | | INTERVAL BETWEEN ONSET AND DEATH 5 hours |
| Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. | DUE TO (b) Generalized Arteriosclerosis | | |
| | DUE TO (c) | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) 331X | | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> 2 |

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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.) None | | |
| 20c. TIME OF INJURY Hour Month, Day, Year a.m. p.m. None | | | | | |

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|---|--|---|---|--|--------------|
| 20d. INJURY OCCURRED WHILE AT <input type="checkbox"/> NOT WHILE <input type="checkbox"/> WORK AT WORK | | 20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) None | 20f. CITY, TOWN, OR LOCATION None | | COUNTY STATE |
|---|--|---|---|--|--------------|

21. I attended the deceased from **1953** to **March 4, 1959** and last saw her alive on **3-4-59**
Death occurred at **5105 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) Ray Tyle, M.D. | | 22b. ADDRESS Versailles - Mo | | 22c. DATE SIGNED 5 March 59 |
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|--|--|------------------------------------|--|--|---|
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial - | | 23b. DATE 7 March - 1959 | 23c. NAME OF CEMETERY OR CREMATORY Versailles - Mo | | 23d. LOCATION (City, town, or county) Versailles - Mo |
|--|--|------------------------------------|--|--|---|

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| 24. FUNERAL DIRECTOR Keith McKay | | ADDRESS ELDON - Mo | 25. DATE RECD. BY LOCAL REG. 3/6/59 | 26. REGISTRAR'S SIGNATURE J L Wash | |
|--|--|------------------------------|---|--|--|

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 *Keith M. Kays*
Licensed Embalmer No. *3998*
P. O. Address *Eldon 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.