Health, & Welfare Public Service

S. 300
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FILED MAR 9 1959

THE DIVISION OF HEALTH OF MISSOURI

# STANDARD CERTIFICATE OF DEATH

59-008033
STATE FILE NUMBER

Registration District No. 324 Primary Registration District No. 3072 Registrar's No. 40

1. PLACE OF DEATH
a. COUNTY Saline
b. CITY OR TOWN Marshall — Inside Limits Yes [X] No [ ]
c. FULL NAME OF HOSPITAL OR INSTITUTION (If NOT in hospital, give location) Fitzgibbon Hosp. — Length of stay in 1b: 10 days

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Missouri b. COUNTY Saline
c. CITY OR TOWN Slater — Inside Limits Yes [X] No [ ]
d. STREET ADDRESS (If outside, give location) 230 E. Emma — Reside on Farm Yes [ ] No [X]

3. NAME OF DECEASED (Type or print): First VINET Middle EMORY Last DULANEY
4. DATE OF DEATH Month March Day 3 Year 1959
5. SEX Male
6. COLOR OR RACE White
7. MARRIED [ ] NEVER MARRIED [ ] WIDOWED [X] DIVORCED [ ]
8. DATE OF BIRTH June 26, 1872
9. AGE (In years last birthday) 86 — 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 farmer
10b. KIND OF BUSINESS OR INDUSTRY none
11. BIRTHPLACE (City and state or country) Jonesboro, Tenn.
12. CITIZEN OF WHAT COUNTRY? USA
13a. FATHER'S NAME DK
13b. MOTHER'S MAIDEN NAME DK
14. NAME OF HUSBAND OR WIFE Nannie B. Dulaney
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no (If yes, give war or dates of service) ---
16. SOCIAL SECURITY NO. None
17. INFORMANT Mrs. W.E. Stouffer, Sr. Slater, 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) Arteriosclerotic heart disease
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.
DUE TO (b) Myocardial Infarction
DUE TO (c) Fractured right hip
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)

19. WAS AUTOPSY PERFORMED? YES [ ] NO [X]

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. I attended the deceased from Feb. 20, 59 to March 3 59 and last saw her/him alive on March 2 59
Death occurred at 3:30 a.m. on the date stated above; and to the best of my knowledge, from the causes stated.

22a. SIGNATURE P.L. Lawless (Degree or title) M.D.
22b. ADDRESS Marshall Mo.
22c. DATE SIGNED 3-4-59

23a. BURIAL, CREMATION, REMOVAL (Specify) Burial
23b. DATE 3/4/1959
23c. NAME OF CEMETERY OR CREMATORY High Hill
23d. LOCATION (City, town, or county) Saline County, Mo. (State)

24. FUNERAL DIRECTOR Haines Funeral Home, Slater, Mo.
ADDRESS
25. DATE RECD. BY LOCAL REG. 3-4-59
26. REGISTRAR'S SIGNATURE Cecil G. Read

(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 Walter J. Haines, Jr.

Licensed Embalmer No. 4557

P. O. Address Slater, 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.