

FILED FEB 17 1959

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

59-008153

State File No.

BIRTH NO. _____		REG. DIST. NO. <u>354</u>		PRIMARY REG. DIST. NO. <u>6198</u>		Registrar's No. <u>4</u>	
1. PLACE OF DEATH a. COUNTY <u>Texas</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Texas</u>			
b. CITY (If outside corporate limits, write RURAL and give town or township) <u>Rural, Cass twp.</u>		c. LENGTH OF STAY (in this place) <u>28 yrs.</u>		c. CITY (If outside corporate limits, write RURAL and give township) <u>Rural, Cass twp.</u>		1070	
d. FULL NAME OF HOSPITAL OR INSTITUTION				d. STREET ADDRESS (If rural, give location) <u>4 miles SE of Elk Creek, Mo.</u>			
3. NAME OF DECEASED (Type or Print)		a. (First) <u>RACHEL</u>		b. (Middle) <u>LUELLA</u>		c. (Last) <u>ELLIOTT</u> <u>Elliott</u>	
4. DATE OF DEATH (Month) (Day) (Year) <u>Jan. 22, 1959</u>		5. SEX <u>female</u>		6. COLOR OR RACE <u>white</u>		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>widowed 2</u>	
8. DATE OF BIRTH <u>Feb. 21, 1876</u>		9. AGE (In years last birthday) <u>82</u>		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) <u>housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Princeton, Missouri</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13a. FATHER'S NAME <u>Charles Scott</u>		13b. MOTHER'S MAIDEN NAME <u>Tulitha Kennedy</u>		14. NAME OF HUSBAND OR WIFE			
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'S SIGNATURE OR NAME <u>Donald Elliott, Rt. 1, Cabool, Mo.</u>		ADDRESS	
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) *This does not mean the mode of dying, such as heart failure, asphyxia, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Congestive Circulatory Failure</u> ANTECEDENT CAUSES DUE TO (b) <u>Basilar Cerebral Thrombosis</u> DUE TO (c) <u>Arteriosclerosis</u> II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.				INTERVAL BETWEEN ONSET AND DEATH	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		332X	
21a. ACCIDENT SUICIDE HOMICIDE (Specify)		21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>Jan 20, 1959</u> , to <u>Jan 22, 1959</u> , that I last saw the deceased alive on <u>Jan 21, 1959</u> , and that death occurred at <u>7:15 p.m.</u> , from the causes and on the date stated above.							
23a. SIGNATURE (Degree or title) <u>Dr. Lawrence Hampton D.O.</u>				23b. ADDRESS <u>Summersville</u>		23c. DATE SIGNED <u>Feb 7</u>	
24a. BURIAL, CREMATION, REMOVAL (Specify) <u>burial</u>		24b. DATE <u>2-25-59</u>		24c. NAME OF CEMETERY OR CREMATORY <u>Miller Cemetery</u>		24d. LOCATION (City, town, or county) (State) <u>Texas County, Missouri</u>	
DATE REC'D BY LOCAL REG. <u>Feb. 13</u>		REGISTRAR'S SIGNATURE <u>Raynell Cunningham</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>James L. Keating, Cabool, Mo.</u>		ADDRESS	

(Licensed Emballer's Statement on Reverse Side)

MAR 3 1959

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
Student Embalmer

Signed James L. Denton
Licensed Embalmer No. 4718
P. O. Address Calvary, Md

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to complete the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.