

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

59-008201

STATE FILE NUMBER

FILED FEB 24 1959

Registration District No.

362

Primary Registration District No.

4531

Registrar's No.

8

300  
-57

1. PLACE OF DEATH a. COUNTY <b>WARREN</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MO</b> b. COUNTY <b>WARREN</b>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>WARRENTON</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <b>WARRENTON</b> <sup>1078</sup> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>Katie Jone Home</b>		Length of stay in lb <b>11 mo</b>	d. STREET ADDRESS (If outside, give location) Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print) First <b>ANNA</b> Middle <b>JANE</b> Last <b>ROYSTON</b>			4. DATE OF DEATH Month <b>2</b> Day <b>10</b> Year <b>59</b>			
---	--	--	---	--	--	--

5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Aug 29 1878</b>	9. AGE (In years last birthday) <b>80</b>	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Hours Min.
-------------------------	----------------------------------	---	--	--	---	--------------------------------

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and state or country) <b>Warren County Mo</b>	12. CITIZEN OF WHAT COUNTRY? <b>yes</b>
---	-----------------------------------	---	--

13a. FATHER'S NAME <b>Marion Maxwell</b>	13b. MOTHER'S MAIDEN NAME <b>Carrie Northcutt</b>	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)	16. SOCIAL SECURITY NO. <b>UNKNOWN</b>	17. INFORMANT <b>Wallace Royston, Jonesburg Mo</b>	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) <b>Senescent arteriosclerosis</b>		INTERVAL BETWEEN ONSET AND DEATH <b>months</b>	
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) <b>arterosclerotic Heart Disease</b>		''
	DUE TO (c) <b>Senile Dementia</b>		''
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <b>4200</b>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	

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.)
20c. TIME OF INJURY Hour Month, Day, Year a.m. p.m.	

20d. INJURY OCCURRED WHILE AT <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 **2-29-58** to **2-10-59** and last saw her <sup>him</sup> alive on **2-10-59**  
Death occurred at **6:45 P.** m on the date stated above; and to the best of my knowledge, from the causes stated.

22a. SIGNATURE <b>[Signature]</b>	(Degree or title)	22b. ADDRESS <b>Warrenton Mo.</b>	22c. DATE SIGNED <b>2-12-59</b>
--------------------------------------	-------------------	--------------------------------------	------------------------------------

23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE <b>2-12-59</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Wright City</b>	23d. LOCATION (City, town, or county) (State) <b>Wright City Mo.</b>
--	-----------------------------	--	---

24. FUNERAL DIRECTOR <b>Carl A. Hickey</b>	ADDRESS <b>Jonesburg Mo.</b>	25. DATE RECD. BY LOCAL REG. <b>Feb 14, 1959</b>	26. REGISTRAR'S SIGNATURE <b>Floyd Logan</b>
---	---------------------------------	---	---

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

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 *Carl A. Harding* .....

Licensed Embalmer No. *4115* .....

P. O. Address *Jonesburg, 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.