

Health,
Welfare
Public
Service

THE DIVISION OF HEALTH OF MISSOURI
CERTIFICATE OF DEATH

59-008206
STATE FILE NUMBER

FILED FEB 18 1959 Registration District No. 366 Primary Registration District No. 6241 Registrar's No. 22

300
-57

1. PLACE OF DEATH a. COUNTY <i>Washington</i>		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <i>Missouri</i> COUNTY <i>Washington</i>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <i>Bretton Knapp</i>		Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	c. CITY OR TOWN <i>Potosi</i> 11-50 Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <i>Haskell</i>		Length of stay in 1b <i>2 mo.</i>	d. STREET ADDRESS (If outside, give location) <i>no street address</i>

3. NAME OF DECEASED (Type or print) First <i>Nellie</i> Middle <i>May</i> Last <i>Forester</i>			4. DATE OF DEATH Month <i>Feb.</i> Day <i>13</i> Year <i>1959</i>		
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5. SEX <i>Female</i>	6. COLOR OR RACE <i>white</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> 2. DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>June 19-1880</i>	9. AGE (In years 1 year 1 day) <i>78</i>	IF UNDER 1 YEAR Months <i>7</i> Days <i>26</i>	IF UNDER 24 HRS. Hours <i></i> Min. <i></i>
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>House work</i>	10b. KIND OF BUSINESS OR INDUSTRY <i>own home</i>	11. BIRTHPLACE (City and state or country) <i>Washington Co. Mo.</i>	12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>
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13a. FATHER'S NAME <i>Forbes Jarvis</i>	13b. MOTHER'S MAIDEN NAME <i>Adeline Scott</i>	14. NAME OF HUSBAND OR WIFE
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15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <i>no</i>	16. SOCIAL SECURITY NO.	17. INFORMANT <i>Herbert DeGiggs</i>	Address <i>Potosi Mo.</i>
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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) <i>MYOCARDIAL INFARCTION.</i>		INTERVAL BETWEEN ONSET AND DEATH <i>1WK.</i>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) <i>ARTERIOSCLEROSIS.</i>	
	DUE TO (c) <i>HYPERTENSION.</i>	
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 <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.)
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20c. TIME OF INJURY Hour <i></i> Month, Day, Year <i></i> a.m. <i></i> p.m. <i></i>	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 <i>Potosi Missouri</i>	COUNTY <i></i>	STATE <i></i>
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21. I attended the deceased from <i>Feb 9, 1959</i> to <i>Feb 13, 1959</i> and last saw her alive on <i>Feb 13, 1959</i> . Death occurred at <i>11-35</i> A m on the date stated above; and to the best of my knowledge, from the causes stated.	
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22a. SIGNATURE <i>Joseph R. Burnett DO</i>	(Degree or title)	22b. ADDRESS <i>Potosi Missouri</i>	22c. DATE SIGNED <i>Feb 16, 1959</i>
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23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>	23b. DATE <i>2-16-59</i>	23c. NAME OF CEMETERY OR CREMATORY <i>Madison Cem.</i>	23d. LOCATION (City, town, or county) <i>Potosi Mo.</i>	(State) <i></i>
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24. FUNERAL DIRECTOR <i>Mr. Luther Spahn</i>	ADDRESS <i>Potosi Mo.</i>	25. DATE RECD. BY LOCAL REG. <i>2/17/59</i>	26. REGISTRAR'S SIGNATURE <i>Herbert DeGiggs</i>
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(Licensed Embalmer's Statement of Reverse Side)

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE
MEDICAL CERTIFICATION

Doctor, coroner, etc. must use only standard nomenclature in item 16. No symptoms will be stated. All diseases in Part I must be causally related.

RECEIVED

FEB 17

WASH. COUNTY HEALTH DEPT.

File No. _____

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 *Murphy L. Sparks* _____

Licensed Embalmer No. *4256* _____

P. O. Address *Flat 1000, The* _____

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.