Health, Welfare Public Service

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THE DIVISION OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

59-008615
STATE FILE NUMBER

FILED APR 14 1959

Registration District No. 47 Primary Registration District No. 3008 Registrar's No. 101

1. PLACE OF DEATH
a. COUNTY: Callaway
b. CITY OR TOWN (If outside corporate limits, give TOWNSHIP only): Fulton, Missouri — Inside Limits: Yes [X] No [ ]
c. FULL NAME OF HOSPITAL OR INSTITUTION (If NOT in hospital, give location): St. Hosp. No. 1. — Length of stay in Ib: 2 months

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Missouri b. COUNTY: Saline
c. CITY OR TOWN: Slater c 971 6 — Inside Limits: Yes [X] No [ ]
d. STREET ADDRESS (If outside, give location): 328 N. Broadway — Reside on Farm: Yes [ ] No [ ]

3. NAME OF DECEASED (Type or print): First: Bert Middle: Edward Last: Page

4. DATE OF DEATH Month: March Day: 29 Year: 1959

5. SEX: Male 0

6. COLOR OR RACE: White

7. MARRIED [X] **NEVER MARRIED** [ ] **WIDOWED** [ ] **DIVORCED** [ ]

8. DATE OF BIRTH: 12/23/1876

9. AGE (In years last birthday): 82 — 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): none

10b. KIND OF BUSINESS OR INDUSTRY: None

11. BIRTHPLACE (City and state or country): Cass County Mo 0

12. CITIZEN OF WHAT COUNTRY?: USA

13a. FATHER'S NAME: Unknown

13b. MOTHER'S MAIDEN NAME: Unknown

14. NAME OF HUSBAND OR WIFE: Unknown

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): unk. (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.: unk.

17. INFORMANT Address: St. Hospital No. 1, Fulton, Missouri.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

All diseases in Part I must be causally related.

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) Chronic Brain Syndrome — INTERVAL BETWEEN ONSET AND DEATH
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) ____ DUE TO (c) ____
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a): Broncho pneumonia with abscesses 309X

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

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 Jan. 20, 1959, to March 29, 1959 and last saw her alive on March 29, 1959. Death occurred at 10:05 A.M. on the date stated above; and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title): B Jackson MD 0
22b. ADDRESS: St. Hospital No. 1, Fulton, Mo.
22c. DATE SIGNED: 3/29/59

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE: April 1, 1959
23c. NAME OF CEMETERY OR CREMATORY: Slater City Cemetery
23d. LOCATION (City, town, or county) (State): Slater, Mo.

24. FUNERAL DIRECTOR ADDRESS: Maupin Funeral Home, Fulton, Mo.
25. DATE RECD. BY LOCAL REG.: April 9, 1959
26. REGISTRAR'S SIGNATURE: Maretta Lawrence

(Licensed Embalmer's Statement on Reverse Side)

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 .....

Licensed Embalmer No. 2555

P. O. Address .....

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.