

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

59-008681

STATE FILE NUMBER

ILLU APR 8 1959 Registration District No. 2-9 Primary Registration District No. Registrar's No. 67

1. PLACE OF DEATH a. COUNTY CASS		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MISSOURI b. COUNTY JACKSON	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Peculiar Twp.		Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	c. CITY OR TOWN K.C. Mo. 3568
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Smiles N. of H. U. Ark.		Length of stay in lb _____	d. STREET ADDRESS (If outside, give location) 3215 Chestnut
			Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print) First Middle Last RUTHIE MAE CASTLE			4. DATE OF DEATH Month Day Year 3 30 1959		
5. SEX F	6. COLOR OR RACE Negro	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 3-20-1938	9. AGE (In years last birthday) 21	IF UNDER 1 YEAR Months Days 21
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House wife		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and state or country) PHILLIPS Co. ARKANSAS	12. CITIZEN OF WHAT COUNTRY? U.S.A.	

13a. FATHER'S NAME HARRISON MORRIS	13b. MOTHER'S MAIDEN NAME ELIZAH JONES	14. NAME OF HUSBAND OR WIFE JAMES CASTLE
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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) No	16. SOCIAL SECURITY NO. 429-72-5328	17. INFORMANT JAMES CASTLE, 3215 Chestnut K.C. Mo
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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) Drowning		INTERVAL BETWEEN ONSET AND DEATH 10 min
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) Loss of consciousness	
	DUE TO (c) Blow to head	
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.) Auto accident, car ran into ditch
20c. TIME OF INJURY Hour Month, Day, Year 3 p.m. 3/30/59	

20d. INJURY OCCURRED WHILE AT <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) Highway # 71	20f. CITY, TOWN, OR LOCATION Peculiar	COUNTY Cass	STATE Mo.
21. I attended the deceased from _____, to _____, and last saw her/him alive on _____ Death occurred at _____ m on the date stated above; and to the best of my knowledge, from the causes stated.				

22a. SIGNATURE (Degree or title) J. C. Taylor M.D.	22b. ADDRESS Pleasant Hill, Mo	22c. DATE SIGNED 3/30/59
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23a. BURIAL, CREMATION, REMOVAL (Specify) Removal	23b. DATE 3-31-59	23c. NAME OF CEMETERY OR CREMATORY MARION ARK. Cemetery	23d. LOCATION (City, town, or county) (State) MARION, ARKANSAS
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24. FUNERAL DIRECTOR W. Kenneth Shibley	ADDRESS Amoswell St	25. DATE RECD. BY LOCAL REG. 4-5-1959	26. REGISTRAR'S SIGNATURE Mrs. Ray Sebrer
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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.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE
MEDICAL CERTIFICATION

300
1-57

APR 16 1959

S/S APR 5 1959

CLATSOP COUNTY
HEALTH DEPARTMENT

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 *Robert W. Anderson*

Licensed Embalmer No. *4902*

P. O. Address *Seaside, Or*

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.