

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

59-010249
STATE FILE NUMBER

FILED MAR 23 1959 Registration District No. 237 Primary Registration District No. 4353 Registrar's No. 5

1. PLACE OF DEATH a. COUNTY <i>New Madrid</i>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Michigan</i> b. COUNTY <i>Benewah</i>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <i>Gideon</i>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <i>Flint, Michigan</i>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <i>In Gideon</i>		Length of stay in 1b	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 Middle Last <i>CHARLEY (Name) Livingston</i>			4. DATE OF DEATH Month Day Year <i>2-18-1959</i>		
5. SEX <i>Male</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>11-30-1894</i>	9. AGE (In years last birthday) IF UNDER 1 YEAR IF UNDER 24 HRS. <i>64</i> Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life) <i>Farmer (Retired)</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>none</i>	11. BIRTHPLACE (City and state or country) <i>Malden Mo.</i>	12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	

13. FATHER'S NAME <i>James Livingston</i>		13b. MOTHER'S MAIDEN NAME <i>Naoma Deprow</i>		14. NAME OF HUSBAND OR WIFE <i>Senara Livingston</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <i>yes U.S.A.</i>		16. SOCIAL SECURITY NO. <i>None</i>	17. INFORMANT Address <i>Senara Livingston, Flint, Mich.</i>		

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>Cerebral Hemorrhage</i>			INTERVAL BETWEEN DEATH AND DEATH <i>Feb 15 59</i>
DUE TO (b) <i>Brain arteriosclerosis</i>			
DUE TO (c)			
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.)		
20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year			

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>Flint-15-59 to Flint-18-59</i>	COUNTY	STATE
21. I attended the deceased from Death occurred at <i>Flint-15-59</i>		and last saw her/him alive on <i>Flint-17-59</i> on the date stated above; and to the best of my knowledge, from the causes stated.		

22a. SIGNATURE <i>Dr. A. Carlstrom D.O.</i>	22b. ADDRESS <i>Malden Mo</i>	22c. DATE SIGNED <i>Feb-18-59</i>
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23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>	23b. DATE <i>2-22-1959</i>	23c. NAME OF CEMETERY OR CREMATORY <i>Stanfield Cem</i>	23d. LOCATION (City, town, or county) (State) <i>Clarkton, Mo.</i>
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24. FUNERAL DIRECTOR <i>Lloyd Russell Piggott Inc.</i>	25. DATE RECD. BY LOCAL REG. <i>3-12-59</i>	26. REGISTRAR'S SIGNATURE <i>Mrs F Y Hopkins</i>
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(Licensed Embalmer's Statement on Reverse Side)

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

All diseases in Part I must be causally related.

MAR 8 7 1959

APR 9 1959

[Handwritten signature]

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 *Lloyd M. Russee*

Licensed Embalmer No. *509-Or*

P. O. Address *Stigott, 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.