

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

59-010523

FILED APR 14 1959

Registration District No. 390 Primary Registration District No. 4442 STATE FILE NUMBER Registrar's No.

1. PLACE OF DEATH a. COUNTY <i>Randolph</i>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Missouri</i> b. COUNTY <i>Randolph</i>	
b. CITY (If outside corporate limits, give TOWNSHIP only) <i>Highlee</i>		c. CITY OR TOWN <i>Highlee</i>	
c. FULL NAME OF HOSPITAL OR INSTITUTION		d. STREET ADDRESS (If outside, give location)	
Length of stay in 1b <i>5 months</i>		Reside on Farm Yes ☐ No ☒	

3. NAME OF DECEASED (Type or print) <i>ANDREW JAMES ATKINS</i>			4. DATE OF DEATH Month Day Year <i>April 5 1959</i>		
5. SEX <i>Male</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐	8. DATE OF BIRTH <i>Nov. 4 1872</i>		
9. AGE (In years, if UNDER 1 YEAR, if UNDER 24 HRS Month Day Hours Min.) <i>86</i>					

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Farmer & Carpenter (Retired)</i>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (City and state or country) <i>Howard Co. Mo.</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
13a. FATHER'S NAME <i>John Atkins</i>		13b. MOTHER'S MAIDEN NAME <i>Margaret Woods</i>		14. NAME OF HUSBAND OR WIFE <i>Nellie C. Atkins</i>			
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. <i>None</i>		17. INFORMANT <i>Mrs. A. J. Atkins</i> Address <i>Highlee MO</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>Congestive Circulatory Failure</i>		INTERVAL BETWEEN ONSET AND DEATH <i>72 hrs</i>	
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) <i>Decompensated Hypertension</i>	<i>1 year</i>	
	DUE TO (c) <i>arteriosclerosis</i>	<i>under</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 ☐ NO ☒	
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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 <i>11-10-57</i> to <i>4-5-59</i> and last saw him alive on <i>4-5-59</i> Death occurred at <i>4:15 P</i> on the date stated above; and to the best of my knowledge, from the causes stated.	
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22a. SIGNATURE <i>Dr. M. Brodinson</i> (Degree or title)	22b. ADDRESS <i>Highlee Mo</i>	22c. DATE SIGNED <i>4-6-59</i>
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23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>	23b. DATE <i>April 7 1959</i>	23c. NAME OF CEMETERY OR CREMATORY <i>Mayans Chapel</i>	23d. LOCATION (City, town, or country) (State) <i>South of Highlee MO</i>
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24. FUNERAL DIRECTOR <i>Cater Funeral Home</i>	25. DATE RECD. BY LOCAL REG. <i>Apr 6 59</i>	26. REGISTRAR'S SIGNATURE <i>W. H. Burton</i>
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USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

ALL DISCUSSIONS 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 *Jerry R. Carter*

Licensed Embalmer No. *4906*

P. O. Address *Mobley, 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.