

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

59-010530  
STATE FILE NUMBER

FILED MAR 24 1959 Registration District No. 295 Primary Registration District No. 6015 Registrar's No. 10

300

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1. PLACE OF DEATH a. COUNTY <b>Randolph</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Mo.</b> b. COUNTY <b>Chariton</b>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>Salt Spring Twp.</b>		Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	c. CITY OR TOWN <b>Keytesville</b> <b>02010</b> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>Pleasant View R.H.</b>		Length of stay in 1b <b>8-Yrs.</b>	d. STREET ADDRESS (If outside, give location) <b>Keytesville - 0.111e</b> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print) First <b>Leona</b> Middle ----- Last <b>Witt</b>			4. DATE OF DEATH Month <b>March</b> Day <b>13th</b> Year <b>1959</b>		
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5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> 2. DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>May 13th, 1871</b>	9. AGE (In years last birthday) <b>87</b>	IF UNDER 1 YEAR Months _____ Days _____	IF UNDER 24 HRS. Hours _____ Min. _____
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>	10b. KIND OF BUSINESS OR INDUSTRY <b>None</b>	11. BIRTHPLACE (City and state or country) <b>Keytesville, Mo.</b>	12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>
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13a. FATHER'S NAME <b>William Coy</b>	13b. MOTHER'S MAIDEN NAME <b>Not Known</b>	14. NAME OF HUSBAND OR WIFE <b>William Witt</b>
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15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, or unknown) (If yes, give war or dates of service) <b>No</b>	16. SOCIAL SECURITY NO. <b>None</b>	17. INFORMANT <b>Mrs. Don Guilford</b>	Address <b>Keytesville, Mo.</b>
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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) <b>Fracture of R. Hip -</b>		INTERVAL BETWEEN ONSET AND DEATH <b>3 wks</b>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) _____	9047
	DUE TO (c) _____	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <b>Atresia selenia to fragility -</b>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>

20a. ACCIDENT <input checked="" 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.) <b>Fall at Pleasant View Home. 2/23/59 - going to</b>
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20c. TIME OF INJURY Hour <b>6</b> Month, Day, Year <b>2-23-1959</b> a.m. p.m.	<b>dying room - Fratone - R. Hip</b> 049
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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.) <b>Pleasant View Home</b>	20f. CITY, TOWN, OR LOCATION <b>Huntsville</b>	COUNTY <b>Randolph</b>	STATE <b>Mo.</b>
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21. I attended the deceased from **2/23/59** to **March 12/59** and last saw her alive on **3/12/59**  
Death occurred at **1:15 P.M.** m on the date stated above; and to the best of my knowledge, from the causes stated.

22a. SIGNATURE <b>M.D. Drayer M.D.</b>	(Degree or title)	22b. ADDRESS <b>Huntsville Mo</b>	22c. DATE SIGNED <b>3/16/59</b>
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23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE <b>March 16, 1959</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Asbury Cemetery</b>	23d. LOCATION (City, town, or county) (State) <b>Chariton County, Mo.</b>
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24. FUNERAL DIRECTOR <b>H.D. Garrett</b>	ADDRESS <b>Keytesville, Mo.</b>	25. DATE RECD. BY LOCAL REG. <b>3-16-1959</b>	26. REGISTRAR'S SIGNATURE <b>Mary H. Bentley</b>
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USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

Locust, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed. All diseases 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 *H. D. Garnett* .....

Licensed Embalmer No. *3046* .....  
P. O. Address *Huntville* .....

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.