

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

59-012073

STATE FILE NUMBER

FILED MAR 24 1959

Registration District No.

360

Primary Registration District No.

3076

Registrar's No. 69

1. PLACE OF DEATH a. COUNTY <u>VERNON</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MISSOURI</u> b. COUNTY <u>VERNON</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>NEVADA</u>		c. CITY OR TOWN <u>SHELDON</u> 1080	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>#402 No. Cedar St JONES NURSING HOME</u>		d. STREET ADDRESS (If outside, give location) <u>L</u>	
Length of stay in 1b <u>19 MONTHS</u>		Reside on Farm Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>CLARA</u> Middle <u>B.</u> Last <u>JAMES</u>		4. DATE OF DEATH Month <u>MARCH</u> Day <u>12</u> Year <u>1959</u>	
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>APRIL 7, 1873</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSE WIFE</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>L</u>	11. BIRTHPLACE (City and state or country) <u>CEDAR CO MO</u>
13a. FATHER'S NAME <u>JOHN HICKMAN</u>		13b. MOTHER'S MAIDEN NAME <u>MARTHA ELKINS CALLAHAN</u>	14. NAME OF HUSBAND OR WIFE <u>JOHN JAMES</u>
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	17. INFORMANT Address <u>L</u>
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Hemorrhage.</u> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <u>Hypertension</u> DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>Advanced age</u>			INTERVAL BETWEEN ONSET AND DEATH <u>2 days</u> <u>Don't know</u>
20a. ACCIDENT SUICIDE HOMICIDE <input type="checkbox"/> <input type="checkbox"/> <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 _____ am. _____ p.m. Month, Day, Year _____		20d. INJURY OCCURRED WHILE AT WORK <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 <u>Nevada</u> COUNTY <u>Vernon</u> STATE <u>MO</u>	
21. I attended the deceased from <u>Feb 1959</u> to <u>Mar 12/59</u> and last saw her alive on <u>Mar 11th 59</u> . Death occurred at <u>12:25 AM</u> on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE <u>W. L. O'NEAL MD</u>		22b. ADDRESS <u>Nevada MO</u>	
22c. DATE SIGNED <u>3-15-59</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	23b. DATE <u>March 13-1959</u>	23c. NAME OF CEMETERY OR CREMATORY <u>SHELDON CEMETERY</u>	23d. LOCATION (City, town, or county) (State) <u>Sheldon, Missouri</u>
24. FUNERAL DIRECTOR <u>BEENEY FUNERAL HOME</u>		25. DATE RECD. BY LOCAL REG. <u>3-21-1959</u>	
ADDRESS <u>SHELDON MO</u>		26. REGISTRAR'S SIGNATURE <u>Anna E. Furry</u>	

(Licensed Embalmer's Statement on Reverse Side)

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

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.

MAR 30 1959

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. Bernard Bung*

Licensed Embalmer No. *4161*

P. O. Address *Sheldon 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.