

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

59-012165
STATE FILE NUMBER

FILED MAY 4 1959 Registration District No. 1 Primary Registration District No. 3000 Registrar's No. 134

1. PLACE OF DEATH a. COUNTY Adair		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Mo. b. COUNTY Adair	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Kirksville		c. CITY OR TOWN Kirksville	
c. FULL NAME OF (IF NOT in hospital, give location) HOSPITAL OR INSTITUTION 505 S. Davis		d. STREET ADDRESS (If outside, give location) 505 S. Davis	
Length of stay in 1b 7 Mo.		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	

3. NAME OF DECEASED (Type or print) Mary Ethel O'Rourke			4. DATE OF DEATH Month Day Year April 25, 1959		
5. SEX F	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Jan. 13, 1891		9. AGE (In years last birthday) 68
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Own Home	11. BIRTHPLACE (City and state or country) Knox Co. Mo.		12. CITIZEN OF WHAT COUNTRY USA

13a. FATHER'S NAME Rhoda Flynn		13b. MOTHER'S MAIDEN NAME Sarah Maloney		14. NAME OF HUSBAND OR WIFE Thomas O'Rourke	
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. None	17. INFORMANT Address Mrs. Howard Strickler Kirksville		

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute myocardial infarction.		INTERVAL BETWEEN ONSET AND DEATH 2 hours
DUE TO (b) Paroxysmal tachycardia.		
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 Month, Day, Year a.m. p.m.					

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 Kirksville, Missouri	COUNTY	STATE
21. Attended the deceased from 4-25-59 to 4-25-59 and last saw her alive on 4-25-59 Death occurred at 8:30 p.m. on the date stated above; and to the best of my knowledge, from the causes stated.					
22a. SIGNATURE (Degree or title) O. W. Hasselblad, M.D.			22b. ADDRESS Kirksville, Missouri		22c. DATE SIGNED 4-27-59

23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE 4-28-1959	23c. NAME OF CEMETERY OR CREMATORY St. Joseph's New	23d. LOCATION (City, town, or county) (State) Edina, Mo.
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24. FUNERAL DIRECTOR Kriegshauser Bros.	ADDRESS Edina, Mo.	25. DATE RECD. BY LOCAL REG. 4-28-1959	26. REGISTRAR'S SIGNATURE Doris W. Ratliff
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All diseases in Part I must be causally related.

MEDICAL CERTIFICATION
USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE
O. W. HASSELBLAD, M.D.

JUN 3 1951

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 *Paul C. Kriegshauser*

Licensed Embalmer No. *4085*
P. O. Address *Edina 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.