

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

59-012906

STATE FILE NUMBER

FILED MAY 5 1959 Registration District No. 120 Primary Registration District No. Registrar's No. 35

1. PLACE OF DEATH a. COUNTY <u>GENTRY</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MISSOURI</u> b. COUNTY <u>GENTRY</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>STANBERRY</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <u>DARLINGTON</u> 0380 Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>HARMONY HILL</u>		Length of stay in 1b <u>2 WKS.</u>	d. STREET ADDRESS (If outside, give location) <u>MAIN ST.</u> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Middle Last <u>EMMA MITT TENNYSON</u>			4. DATE OF DEATH Month Day Year <u>APRIL 18, 1959</u>
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>MAY 6, 1867</u>
9a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>		9b. KIND OF BUSINESS OR INDUSTRY <u>HOME</u>	9. AGE (In years last birthday) <u>91</u> IF UNDER 1 YEAR: Months Days Hours Min. IF UNDER 24 HRS.
10a. FATHER'S NAME <u>JOHN W. BURGESS</u>		10b. BIRTHPLACE (City and state or country) <u>WAPELLO, Co., Iowa</u>	10c. CITIZEN OF WHAT COUNTRY? <u>USA.</u>
11. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>NO</u>		11b. SOCIAL SECURITY NO. <u>NONE</u>	11c. INFORMANT <u>MRS. KATHRYN ENOCHS, DARLINGTON, Mo.</u> Address
12. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Arteriosclerotic Cerebrovascular disease - years.</u>		INTERVAL BETWEEN ONSET AND DEATH	
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <u>unknown</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>Urinary infection, hypertrophic arthritis 42.21</u>		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 COUNTY STATE
21. I attended the deceased from <u>Aug 26, 1952</u> to <u>April 18, 1959</u> and last saw her ^{her} alive on <u>April 11, 1959</u> Death occurred at <u>11:30 p.</u> on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE <u>Clifford L. Carlen, M.D.</u> (Degree or title)		22b. ADDRESS <u>Stanberry, Mo.</u>	22c. DATE SIGNED <u>4-23-59</u>
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	23b. DATE <u>4-21-59</u>	23c. NAME OF CEMETERY OR CREMATORY <u>LONG BRANCH</u>	23d. LOCATION (City, town, or county) (State) <u>STANBERRY, MO.</u>
24. FUNERAL DIRECTOR <u>JOHNSON E. H. STANBERRY, Mo.</u>		25. DATE RECD. BY LOCAL REG. <u>4/26/59</u>	26. REGISTRAR'S SIGNATURE <u>Mrs. L. W. Bare</u>

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

Doctor, coroner, etc.: most use only standard abbreviations in their reports. 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 *Eric E. Johnson*

Licensed Embalmer No. *4948*

P. O. Address *Stanberry*

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.