Health, & Welfare Public Service

5. 300
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THE DIVISION OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

59-014384
STATE FILE NUMBER

FILED MAY 13 1959 Registration District No. 275 Primary Registration District No. 3053 Registrar's No. 72

1. PLACE OF DEATH
a. COUNTY Phelps
b. CITY OR TOWN Rolla — Inside Limits Yes ☑ No ☐
c. FULL NAME OF HOSPITAL OR INSTITUTION Farland Rest Home — Length of stay in Hospital 3 yrs

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Missouri b. COUNTY St. Francois
c. CITY OR TOWN Flat River — Inside Limits Yes ☒ No ☐
d. STREET ADDRESS 1 Nowume (If outside, give location) — Reside on Farm Yes ☐ No ☒

3. NAME OF DECEASED (Type or print) First Eliza Middle Edna Last Karles
4. DATE OF DEATH Month April Day 27 Year 1959
5. SEX Female
6. COLOR OR RACE White
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH Sept. 12 1867
9. AGE (In years on last birthday) 91 — IF UNDER 1 YEAR Months 7 Days 15 — IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House work
10b. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (City and state or country) Washington Co Mo
12. CITIZEN OF WHAT COUNTRY? U S A
13a. FATHER'S NAME John Campbell
13b. MOTHER'S MAIDEN NAME Susan Meyers
14. NAME OF HUSBAND OR WIFE Deceased
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, unknown) No (If yes, give war or dates of service)
16. SOCIAL SECURITY NO. No
17. INFORMANT Minnie Alexander Address Farmington Mo.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Bronchial Pneumonia — INTERVAL BETWEEN ONSET AND DEATH 1 wk.
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) Senility
DUE TO (c)
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) 491X
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒ 2

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 12/8/55, to 4/27/59 and last saw her alive on 4/27/59
Death occurred at 7:15 P m on the date stated above; and to the best of my knowledge, from the causes stated.

22a. SIGNATURE Wm R Goffe M.D. (Degree or title)
22b. ADDRESS Rolla Mo
22c. DATE SIGNED 4/27/59

23a. BURIAL, CREMATION, REMOVAL (Specify) Burial
23b. DATE 4-29-59
23c. NAME OF CEMETERY OR CREMATORY Shirley Cemetery
23d. LOCATION (City, town, or county) (State) Washington Co. Mo.
24. FUNERAL DIRECTOR Oman Jenkins ADDRESS Potosi Mo.
25. DATE RECD. BY LOCAL REG. May 4, 1959
26. REGISTRAR'S SIGNATURE Nadine L. Stoll

(Licensed Embalmer's Statement on Reverse Side)

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.

Date Filed [illegible]

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 Murphy L. Span[illegible]

Licensed Embalmer No. 4236

P. O. Address [illegible]

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.