

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

59-014493

STATE FILE NUMBER

FILED MAY 5 1959 Registration District No. 390 Primary Registration District No. 6041 Registrar's No.

300
1-57

Health,
Welfare
Public
Service

All diseases in Part I must be causally related.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

1. PLACE OF DEATH a. COUNTY Randolph		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY Randolph	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Moniteau		c. CITY OR TOWN R. F. D Higbee Mo	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION R. F. D. Higbee		d. STREET ADDRESS (If outside, give location)	
3. NAME OF DECEASED (Type or print) First Rosy Middle Lee Last Lyle		4. DATE OF DEATH Month April Day 19 Year 1959	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH May 9 1884
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House Wife		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and state or country) Scotland Co. Mo
12. CITIZEN OF WHAT COUNTRY? U. S. A		13a. FATHER'S NAME Randolph Woods	
13b. MOTHER'S MAIDEN NAME Alice Bryant		14. NAME OF HUSBAND OR WIFE Tommie Lyle	
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. No	17. INFORMANT Tommie Lyle Higbee Mo
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Congestive Circulatory Failure Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. } DUE TO (b) Decompensated Hypertensive Heart Disease DUE TO (c) Advanced Arteriosclerosis			INTERVAL BETWEEN ONSET AND DEATH 72 hrs 2 years unknown
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.) 443X	
20c. TIME OF INJURY Hour <input type="checkbox"/> Month, Day, Year <input type="checkbox"/> a.m. <input type="checkbox"/> p.m. <input type="checkbox"/>		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 COUNTY STATE	
21. I attended the deceased from 6-21-54 to 4-19-59 and last saw her alive on 4-19-59 Death occurred at 9:30 AM on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE Per Y. Brown sm 200		22b. ADDRESS Higbee Mo	
22c. DATE SIGNED 4-20-59		22d. DATE SIGNED	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE April 21 1959	
23c. NAME OF CEMETERY OR CREMATORY Fairview		23d. LOCATION (City, town, or county) (State) South of Higbee Mo	
24. FUNERAL DIRECTOR Burton Funeral Home		25. DATE RECD. BY LOCAL REG. 4-21-59	
26. REGISTRAR'S SIGNATURE Joe W. Burton		26. REGISTRAR'S SIGNATURE	

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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 *[Handwritten Signature]*

Licensed Embalmer No. *3978*

P. O. Address *[Handwritten Address]*

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.