

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

59-014592

STATE FILE NUMBER

FILED MAY 11 1959

Registration District No. 316 Primary Registration District No. _____ Registrar's No. 173

300
1-57

1. PLACE OF DEATH a. COUNTY <u>St. Francois</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Scott</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) <u>St. Francois Township</u>		Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	c. CITY OR TOWN <u>Illmo</u> <u>10000</u> Inside Limits Yes <input type="checkbox"/> Unknown <input checked="" type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>State Hospital #4</u>		Length of stay in 1b <u>1yr.; 3M; 21das.</u>	d. STREET ADDRESS (If outside, give location) <u>Unknown.</u> Residence on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print) First <u>WILLIAM</u> Middle _____ Last <u>HERRING</u>			4. DATE OF DEATH Month <u>April</u> Day <u>20</u> , Year <u>1959</u>
--	--	--	---

5. SEX <u>Male</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>Sept. 1878</u>	9. AGE (In years at birthday) <u>80</u>	IF UNDER 1 YEAR Months _____ Days _____	IF UNDER 24 HRS. Hours _____ Min. _____
-----------------------	----------------------------------	---	---------------------------------------	--	--	--

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Unknown</u>	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and state or country) <u>Unknown</u>	12. CITIZEN OF WHAT COUNTRY? <u>Unknown</u>
---	-----------------------------------	--	--

13a. FATHER'S NAME <u>Unknown</u>	13b. MOTHER'S MAIDEN NAME <u>Unknown</u>	14. NAME OF HUSBAND OR WIFE <u>Gennie Goodman</u>
--------------------------------------	---	--

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>	16. SOCIAL SECURITY NO. <u>Unknown</u>	17. INFORMANT <u>Records, State Hospital No. 4, Farmington, Mo.</u>	Address _____
--	---	--	---------------

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>	INTERVAL BETWEEN ONSET AND DEATH <u>24 hrs.</u>
---	--

Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) <u>Cerebral arteriosclerosis</u>	Unknown
--	---	---------

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>Diabetes Melitus and Psychosis with cerebral arteriosclerosis.</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 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 <u>Dec. 30, 1957</u> to <u>April 20, 1959</u> and last saw him alive on <u>April 20, 1959</u> Death occurred at <u>5:30 A. M.</u> on the date stated above; and to the best of my knowledge, from the causes stated.
--

22a. SIGNATURE (Degree or title) <u>John A. Bolens M.D.</u>	22b. ADDRESS <u>State Hospital No. 4 Farmington, Missouri</u>	22c. DATE SIGNED <u>4-20-59</u>
--	--	------------------------------------

23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>	23b. DATE <u>April 21, 1959</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Washington Univ. Anat. Dept.</u>	23d. LOCATION (City, town, or county) (State) <u>St. Louis, Missouri</u>
---	------------------------------------	---	---

24. FUNERAL DIRECTOR <u>Via Cozean Funeral Home, Farmington, Mo.</u>	25. DATE RECD. BY LOCAL REG. <u>May 6, 1959</u>	26. REGISTRAR'S SIGNATURE <u>Ether Rudloff</u>
---	--	---

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

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.

NOT EMBALMED

Student
Signature of Student Embalmer

Signed

Licensed Embalmer No.....

P. O. 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.