Health, Welfare Public Service

300 -57

THE DIVISION OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

59-016482
STATE FILE NUMBER

FILED MAY 11 1959

Registration District No. 381 Primary Registration District No. 6174 Registrar's No. 39

1. PLACE OF DEATH a. COUNTY Sullivan	2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Mo. b. COUNTY Sullivan
b. CITY OR TOWN (If outside corporate limits, give TOWNSHIP only) Harris Rural — Inside Limits Yes ☐ No ☒	c. CITY OR TOWN Harris - Rural 105 — Inside Limits Yes ☐ No ☒
c. FULL NAME OF HOSPITAL OR INSTITUTION (If NOT in hospital, give location) Clay Twp — Length of stay in 1b	d. STREET ADDRESS (If outside, give location) Clay Twp. — Reside on Farm Yes ☒ No ☐

3. NAME OF DECEASED (Type or print) First Middle Last: Clarence Oden Deeds

4. DATE OF DEATH Month Day Year: 5 - 3 - 1959

5. SEX: M

6. COLOR OR RACE: W

7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: 2-22-1892

9. AGE (In years last birthday): 67 — IF UNDER 1 YEAR Months 2 Days 11 — IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Farmer

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (City and state or country): Pollock - Mo

12. CITIZEN OF WHAT COUNTRY? U.S.

13a. FATHER'S NAME: Geo. Deeds

13b. MOTHER'S MAIDEN NAME: Almeta Montgomery

14. NAME OF HUSBAND OR WIFE: —

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes (If yes, give war or dates of service) WWI.

16. SOCIAL SECURITY NO.:

17. INFORMANT: Daisy Deeds — Address: Milan - Mo

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): coronary occlusion — INTERVAL BETWEEN ONSET AND DEATH: instant

Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.

DUE TO (b): —

DUE TO (c): —

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a): — 4261

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

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 —, to — and last saw her/him alive on —

Death occurred at 5-3-59 1 A m on the date stated above; and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title): Eric Simpson D.O. Coroner 3

22b. ADDRESS: Milan

22c. DATE SIGNED: 5-5-59

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE: 5-6-59

23c. NAME OF CEMETERY OR CREMATORY: Deeds Cem.

23d. LOCATION (City, town, or county) (State): Sullivan Co. Mo.

24. FUNERAL DIRECTOR: Schoene's Dwight Schoene — ADDRESS: Milan Mo

25. DATE RECD. BY LOCAL REG.: 5-7-59

26. REGISTRAR'S SIGNATURE: Mrs. M. W. Beckett

(Licensed Embalmer's Statement on Reverse Side)

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

All diseases in Part I must be causally related.

MAY 28 1959

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 .....Dwight Schoene.....

Licensed Embalmer No. 2667

P. O. Address ....Milan - Mi

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.