

Health,
& Welfare
Public
Service

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

59-016533

STATE FILE NUMBER

FILED APR 28 1959 Registration District No. 360 Primary Registration District No. 3076 Registrar's No. 88

S. 300
1-57

1. PLACE OF DEATH a. COUNTY <u>Vernon</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Andrew</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Nevada</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <u>Savannah</u> <u>0020</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If not in institution) HOSPITAL OR INSTITUTION <u>Tates Nursing Home</u>		length of stay in 1b <u>4 weeks</u>	d. STREET ADDRESS (If outside, give location) <u>310 First Street</u> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print) First <u>John</u> Middle <u>Robert</u> Last <u>White</u>			4. DATE OF DEATH Month <u>April</u> Day <u>14</u> Year <u>1959</u>		
---	--	--	---	--	--

5. SEX <u>Male</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>Aug. 2, 1859</u>	9. AGE (In years last birthday) <u>99</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>Retired Farmer</u>	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and state or country) <u>Missouri</u>	12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>
--	-----------------------------------	---	---

13a. FATHER'S NAME <u>Lyman A. White</u>	13b. MOTHER'S MAIDEN NAME <u>Elizabeth C. Briggs</u>	14. NAME OF HUSBAND OR WIFE <u>Verdie White</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>none</u>	17. INFORMANT <u>C. A. White</u> Address <u>Nevada, Missouri</u>
--	--	---

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>Brain pneumonia</u> DUE TO (b) <u>Myocardial insufficiency</u> DUE TO (c) <u>Serulite</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH, but not related to the terminal disease condition given in PART I (a) <u>4222</u>		INTERVAL BETWEEN ONSET AND DEATH <u>7 weeks</u>
--	--	--

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 _____ 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>3-23-59</u> to <u>4-14-59</u> and last saw him alive on <u>4-14-59</u> Death occurred at <u>10:30 PM</u> on the date stated above; and to the best of my knowledge, from the causes stated.
--

22a. SIGNATURE <u>F. E. Martin</u> (Degree or title) <u>M.D.</u>	22b. ADDRESS <u>Nevada Mo.</u>	22c. DATE SIGNED <u>4-15-59</u>
---	-----------------------------------	------------------------------------

23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>	23b. DATE <u>4/14/59</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Whiteville Cemetery</u>	23d. LOCATION (City, town, or county) <u>Whiteville, Missouri</u> (State)
---	-----------------------------	--	---

24. FUNERAL DIRECTOR <u>Breit Funeral Home Savannah, Mo.</u>	25. DATE RECD. BY LOCAL REG. <u>4-20-1959</u>	26. REGISTRAR'S SIGNATURE <u>U. M. & Jerry</u>
---	--	---

(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.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE
MEDICAL CERTIFICATION

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 *Arcy F. Milster*

Licensed Embalmer No. *4805*
P. O. Address *Nebraska Mo.*

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.