Health, Welfare Public Service

300
1-57

THE DIVISION OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

59-016557
STATE FILE NUMBER

APR 28 1959 Registration District No. 360 Primary Registration District No. 6225 Registrar's No. 68

1. PLACE OF DEATH
a. COUNTY Vernon
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Washington Township — Inside Limits Yes ☐ No ☒
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION State Hospital #3 — Length of stay in Ib 2 mos 21 days

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Missouri b. COUNTY Bates
c. CITY OR TOWN Rich Hill 0070 — Inside Limits Yes ☒ No ☐
d. STREET ADDRESS 8th and Spruce St. (If outside, give location) — Reside on Farm Yes ☐ No ☒

3. NAME OF DECEASED (Type or print): First NORA Middle MAGDALENE Last STONE
4. DATE OF DEATH: Month 4 Day 19 Year 1959
5. SEX: F
6. COLOR OR RACE: W.
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ 2 DIVORCED ☐
8. DATE OF BIRTH: 3-19-1874
9. AGE (In years last birthday): 85 — 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): Housewife
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (City and state or country): Warrenton, Mo.
12. CITIZEN OF WHAT COUNTRY? U. S. A
13a. FATHER'S NAME: James Lewis
13b. MOTHER'S MAIDEN NAME: Anna Border
14. NAME OF HUSBAND OR WIFE: Unknown
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.: none
17. INFORMANT: Hospital record — Address

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) Arteriosclerotic heart disease — INTERVAL BETWEEN ONSET AND DEATH: years
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.
DUE TO (b) Arteriosclerosis — years
DUE TO (c) 4200
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 ☐ 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 1/29/1959, to 4/19/1959 and last saw her/him alive on 4/19/1959
Death occurred at 9:45 p.m. on the date stated above; and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) George Eisker M. D.
22b. ADDRESS State Hospital No. 3 Nevada, Mo.
22c. DATE SIGNED 4/19/1959

23a. BURIAL, CREMATION, REMOVAL (Specify) Burial
23b. DATE 4/24/59
23c. NAME OF CEMETERY OR CREMATORY Green Lawn Cem.
23d. LOCATION (City, town, or county) (State) Rich Hill, Missouri.

24. FUNERAL DIRECTOR Booth Funeral Serv. ADDRESS Rich Hill, Mo.
25. DATE RECD. BY LOCAL REG. 4-24-1959
26. REGISTRAR'S SIGNATURE Omal E. Jerry

(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.

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 John G. Underwood

Licensed Embalmer No. 3583

P. O. Address Butler, Tenn.

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.