

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

59-016588

STATE FILE NUMBER

Registration District No. 374

Primary Registration District No.

Registrar's No. 15

FILED APR 21 1959

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-57

1. PLACE OF DEATH a. COUNTY Worth County Missouri		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY Worth	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Grant City Missouri		c. CITY OR TOWN Grant City Missouri	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION 800 South Lyons		d. STREET ADDRESS (If outside, give location) 108 Lyons St	
3. NAME OF DECEASED (Type or print) First Mary Middle Josephine Last Tandy		4. DATE OF DEATH Month April Day 4 Year 1959	
5. SEX female	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH February 18 1871
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife		10b. KIND OF BUSINESS OR INDUSTRY housewife	9. AGE (In years last birthday) 88
11. BIRTHPLACE (City and state or country) Olena Illinois		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13a. FATHER'S NAME James Elisha Richardson		13b. MOTHER'S MAIDEN NAME Kiziah Caress	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) no		17. INFORMANT Sam Tandy Grant City Missouri	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Thromboses, multiple Arteriosclerosis, generalized 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) _____		INTERVAL BETWEEN ONSET AND DEATH 2 weeks 10 yrs	
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 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 _____ 1950 to _____ 1959 and last saw her alive on _____ Apr 4, 59 Death occurred at _____ 9pm m on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE Frank B Matteson MD (Degree of title) Frank B Matteson MD		22b. ADDRESS Grant City, Mo	
22c. DATE SIGNED 4/7/59		23c. NAME OF CEMETERY OR CREMATORY Grant City Cemetery	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE April 7 1959	
24. FUNERAL DIRECTOR John Andrews Grant City Missouri		25. DATE RECD. BY LOCAL REG. April 18 1959	
26. REGISTRAR'S SIGNATURE Bowdley Kibbe		23d. LOCATION (City, town, or county) Grant City Missouri (State)	

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE
MEDICAL CERTIFICATION

All diseases in Part I must be causally related.

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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 John Andrews, Student Embalmer No. working under my personal supervision.

Student
Signature of Student Embalmer

Signed John Andrews
Licensed Embalmer No. 4211

P. O. Address Grant City, 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.