Health, Welfare Public Service

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1-57

THE DIVISION OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

59-016724
STATE FILE NUMBER

FILED JUN 15 1959 Registration District No. 38 Primary Registration District No. 3006 Registrar's No. 259

1. PLACE OF DEATH
a. COUNTY: Boone
b. CITY OR TOWN (If outside corporate limits, give TOWNSHIP only): Columbia — Inside Limits: Yes [X] No [ ]
c. FULL NAME OF HOSPITAL OR INSTITUTION (If NOT in hospital, give location): Univ. Med. center — Length of stay in lb: 1 day

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Missouri b. COUNTY: Pemiscot
c. CITY OR TOWN: Caruthersville — Inside Limits: Yes [X] No [ ]
d. STREET ADDRESS (If outside, give location): 14th and Schult — Reside on Farm: Yes [ ] No [X]

3. NAME OF DECEASED (Type or print): First ROBERT Middle ESTES Last EASTRIDGE
4. DATE OF DEATH: Month June Day 11 Year 1959

5. SEX: Male
6. COLOR OR RACE: white
7. MARRIED [ ] NEVER MARRIED [ ] WIDOWED [X] DIVORCED [ ]
8. DATE OF BIRTH: Nov. 25, 89
9. AGE (In years last birthday): 69 — 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): Logger
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (City and state or country): Clarkton Mo
12. CITIZEN OF WHAT COUNTRY? U.S.A

13a. FATHER'S NAME: Lark Eastridge
13b. MOTHER'S MAIDEN NAME: Margaret Paige
14. NAME OF HUSBAND OR WIFE:

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.: 491-18-3091
17. INFORMANT: Hospital Record — Address: Columbia 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): GANGRENE OF SMALL INTESTINE — INTERVAL BETWEEN ONSET AND DEATH: ?
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.
DUE TO (b): MESENTERIC THROMBOSIS — 2-3 WKS
DUE TO (c): 5702
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a): UREMIA, PROBABLY DUE TO DEHYDRATION
19. WAS AUTOPSY PERFORMED? YES [X] 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 6/10/59, to 6/11/59 and last saw ~~her~~ him alive on 6/11/59
Death occurred at 5:30 A m on the date stated above; and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title): J S Sanders M.D.
22b. ADDRESS: Univ of Mo Med Center
22c. DATE SIGNED: 6/11/59

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE: 6-13-59
23c. NAME OF CEMETERY OR ~~CREMATORY~~: Little Prairie
23d. LOCATION (City, town, or county) (State): Caruthersville Mo.

24. FUNERAL DIRECTOR — ADDRESS: Parker Funeral Service Columbia Mo
25. DATE RECD. BY LOCAL REG.: June 11 1959
26. REGISTRAR'S SIGNATURE: Mrs R E Palmer

(Licensed Embalmer's Statement on Reverse Side)

All diseases in Part I must be causally related.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

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

Student .....
Signature of Student Embalmer

Signed Douglas P. Gorman

Licensed Embalmer No. 5037

P. O. Address Columbia, M

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.