

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

59-017173  
STATE FILE NUMBER

FILED JUN 8 1959 Registration District No. 83 Primary Registration District No. 5321 Registrar's No. 6

300  
1-57

1. PLACE OF DEATH a. COUNTY <u>Cooper</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MISSOURI</u> b. COUNTY <u>MONITEAU</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Calitornia - 50 mi. E. W. 11</u> Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>		c. CITY OR TOWN <u>Calitornia</u> Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION		Length of stay in lb	d. STREET ADDRESS (If outside, give location) <u>660</u> Reside on Farm Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>

3. NAME OF DECEASED (Type or print) First Middle Last <u>LUCY JANE REX</u>			4. DATE OF DEATH Month Day Year <u>May 31 1959</u>		
5. SEX <u>Female</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>Feb-2-1896</u>	9. AGE (In years last birthday) IF UNDER 1 YEAR IF UNDER 24 HRS. <u>83</u> Months <u>3</u> Days <u>29</u> Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>No</u>	11. BIRTHPLACE (City and state or country) <u>Cooper County Mo</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>
13a. FATHER'S NAME <u>MATHEW J. TOLLER</u>		13b. MOTHER'S MAIDEN NAME <u>Nancy J. Vaughan</u>		14. NAME OF HUSBAND OR WIFE <u>George REX</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, unknown) (If yes, give year or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>No</u>	17. INFORMANT Address <u>George Rex Jr. California Mo</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>Cerebral Thrombosis</u>		INTERVAL BETWEEN ONSET AND DEATH <u>3 weeks</u>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <u>Cerebral and General Arteriosclerosis</u>		<u>5+ years</u>
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 <input type="checkbox"/> NO <input checked="" type="checkbox"/>

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 Month, Day, Year 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 <u>Cooper Mo</u>
21. I attended the deceased from <u>5-8-59</u> to <u>5-28-59</u> and last saw her alive on <u>5-28-59</u> Death occurred at <u>7:00 am</u> on the date stated above; and to the best of my knowledge, from the causes stated.		
22a. SIGNATURE (Degree or title) <u>R.B. Fultz MD</u>	22b. ADDRESS <u>California, Mo</u>	22c. DATE SIGNED <u>6-1-59</u>

23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE <u>6-2-1959</u>	23c. NAME OF CEMETERY OR CREMATORY <u>MT. PLEASANT Cem.</u>	23d. LOCATION (City, town, or county) (State) <u>California Mo</u>
24. FUNERAL DIRECTOR ADDRESS <u>Hugh E. Killiam California Mo</u>	25. DATE RECD. BY LOCAL REG. <u>6/2/59</u>	26. REGISTRAR'S SIGNATURE <u>Virginia T. Higgins</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 *Hugh E. Williams*.....

Licensed Embalmer No. *3537*.....

P. O. Address *California*.....

- 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.