

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

59-018374
STATE FILE NUMBER

FILED MAY 27 1959

Registration District No. 187 Primary Registration District No. 3040 Registrar's No. 141

300
1-57

1. PLACE OF DEATH a. COUNTY <i>Livingston</i>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Missouri</i> b. COUNTY <i>Carroll</i>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <i>Chillicothe</i>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <i>Carrollton</i> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <i>Susan's Rest Home</i>		Length of stay in lb <i>6 mto</i>	d. STREET ADDRESS (If outside, give location) <i>407 N. Lodie Street</i> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print) First <i>Hattie</i> Middle <i>Gertrude</i> Last <i>O'Bryan</i>			4. DATE OF DEATH Month <i>May</i> Day <i>22</i> Year <i>1959</i>		
5. SEX <i>Female</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>Oct. 6. 1878</i>	9. AGE (In years last birthday) <i>80</i>	IF UNDER 1 YEAR: Months <i>7</i> Days <i>16</i> Hours <i></i> Min. <i></i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>House Wife</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>House Work</i>	11. BIRTHPLACE (City and state or country) <i>Marion County Mo.</i>	12. CITIZEN OF WHAT COUNTRY? <i>U. S. A.</i>	

13a. FATHER'S NAME <i>John Ashford</i>	13b. MOTHER'S MAIDEN NAME <i>Sarah White</i>	14. NAME OF HUSBAND OR WIFE <i>Jeremiah O'Bryan (Deceased)</i>
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <i>No</i>	16. SOCIAL SECURITY NO. <i>None</i>	17. INFORMANT <i>Estes O'Bryan Carrollton Mo.</i> Address

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Pulmonary Embolism</i>		INTERVAL BETWEEN ONSET AND DEATH <i>24 hrs.</i>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <i>Congestive Heart Failure</i>		<i>12-18 mts.</i>
DUE TO (c) <i>Senility</i>		<i>6-10 yrs.</i>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <i>4341</i>		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 <i></i> Month, Day, Year a.m. <i></i> p.m. <i></i>	

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 <i>Chillicothe, Mo.</i>	COUNTY <i>Carrollton</i>	STATE <i>Mo.</i>
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21. I attended the deceased from *JUNE 10 - 58* to *May 22 - 59* and last saw her/him alive on *5/22/59*.
Death occurred at *5:04 P.M.* m on the date stated above; and to the best of my knowledge, from the causes stated.

22a. SIGNATURE <i>R. W. Matheny</i> (Degree or title) <i>2</i>	22b. ADDRESS <i>Chillicothe, Mo.</i>	22c. DATE SIGNED <i>5/23/59</i>
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23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>	23b. DATE <i>5-24-59</i>	23c. NAME OF CEMETERY OR CREMATORY <i>Oak Hill Cemetery</i>	23d. LOCATION (City, town, or county) (State) <i>Carrollton Mo.</i>
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24. FUNERAL DIRECTOR <i>Marshall G. Home</i> ADDRESS <i>Carrollton Mo.</i>	25. DATE RECD. BY LOCAL REG. <i>5/23/59</i>	26. REGISTRAR'S SIGNATURE <i>Frances B. Neill</i>
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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 Samuel M. Rice....., Student Embalmer No. 577..... working under my personal supervision.

Student Samuel M. Rice.....
Signature of Student Embalmer

Signed R. M. Marshall.....

Licensed Embalmer No. 2525.....

P. O. Address Carrollton 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.