

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

59-018468

FILED JUN 3 1959 Registration District No. 217 Primary Registration District No. 3045 STATE FILE NUMBER Registrar's No. 431

1. PLACE OF DEATH a. COUNTY <b>Mississippi</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Missouri</b> b. COUNTY <b>Mississippi</b>	
b. CITY (If outside corporate limits, give TOWNSHIP only) <b>Charleston</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <b>Charleston</b>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>Home</b>		Length of stay in 1b <b>5 1/2 Yrs</b>	d. STREET ADDRESS (If outside, give location) <b>322 E. Cypress</b>
			Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print) First <b>Ida</b> Middle <b>Bone</b> Last <b>Bone</b>			4. DATE OF DEATH Month <b>May</b> Day <b>8</b> Year <b>1959</b>		
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5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>9/20/1874</b>	9. AGE (In years last birthday) <b>84</b>	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>	10b. KIND OF BUSINESS OR INDUSTRY <b>Self</b>	11. BIRTHPLACE (City and state or country) <b>Hickman Co., Ky</b>	12. CITIZEN OF WHAT COUNTRY? <b>USA.</b>
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13a. FATHER'S NAME <b>Wesley Bone</b>	13b. MOTHER'S MAIDEN NAME <b>Lucinda Austin</b>	14. NAME OF HUSBAND OR WIFE <b>E. F. Bone</b>
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15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>	16. SOCIAL SECURITY NO. -----	17. INFORMANT <b>Mrs. Charles Arnold</b>	Address <b>Charleston, Mo.</b>
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18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral Vascular Accident</b>		INTERVAL BETWEEN ONSET AND DEATH <b>7 days</b>
DUE TO (b) <b>Atherosclerosis</b>		
DUE TO (c) <b>331XF</b>		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <b>Cerebral Accident - Sub-hepatic abscess (drained through abd wall)</b>		

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.)
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20c. TIME OF INJURY Hour Month, Day, Year a.m. p.m.
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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 <b>Charleston, Mo.</b>	COUNTY	STATE
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21. I attended the deceased from <b>7-27-49</b> to <b>5-4-59</b> and last saw her alive on <b>5-4-59</b> Death occurred <b>5-25 A.M.</b> on the date stated above; and to the best of my knowledge, from the causes stated.
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22a. SIGNATURE <i>[Signature]</i>	(Degree or title)	22b. ADDRESS <b>Charleston, Mo.</b>	22c. DATE SIGNED <b>5-28-59</b>
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23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE <b>5/10/59</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Oak Grove</b>	23d. LOCATION (City, town, or county) <b>Charleston, Mo.</b>	(State)
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24. FUNERAL DIRECTOR <b>Mc Mickle, Charleston, Mo.</b>	ADDRESS	25. DATE RECD. BY LOCAL REG. <b>5-29-59</b>	26. REGISTRAR'S SIGNATURE <i>[Signature]</i>
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5. 300  
1-57

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Some symptoms were listed.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

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499

1961  
MAR 2 1980  
JAN 4 196

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 *Edwin McMillan* .....  
Licensed Embalmer No. *4695*

P. O. Address *Chillicothe, 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.