

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

59-018674

FILED MAY 27 1959

Registration District No. 275

Primary Registration District No. 3053

STATE FILE NUMBER

Registrar's No. 84

300  
-57

1. PLACE OF DEATH a. COUNTY <u>Phelps</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Phelps</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Rolla</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <u>Rolla</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>McFarland Nursing Home</u>		Length of stay in lb <u>1 yr 7 mo</u>	0814 STREET ADDRESS <u>205 Rolla ave</u> 0 Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <u>FRANK</u> Middle <u>HUSKEY</u> Last <u>HUSKEY</u>		4. DATE OF DEATH Month <u>April</u> Day <u>8</u> Year <u>1959</u>	
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> 1 WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Oct 17, 1895</u>
9. AGE (In years last birthday) <u>63</u>		IF UNDER 1 YEAR Months <u>5</u> Days <u>14</u>	IF UNDER 24 HRS Hours <u></u> Min. <u></u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farming</u>		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and state or country) <u>Phelps County Mo</u>
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13a. FATHER'S NAME <u>Marion Huskey</u>	
13b. MOTHER'S MAIDEN NAME <u>Amanda Ford</u>		14. NAME OF HUSBAND OR WIFE <u>Jennie Huskey</u>	
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. <u>480504011</u>	17. INFORMANT <u>Jennie Huskey</u> Address <u>205 Rolla ave Rolla</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>Pneumonia, Hypostatic</u> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. } DUE TO (b) <u>Cerebral Uremia</u> DUE TO (c) <u>Hypertension, essential</u>			INTERVAL BETWEEN ONSET AND DEATH <u>3 days</u> <u>5 wks.</u> <u>5 yrs.</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>Multiple "Strokes"</u>			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 a.m. p.m. Month, Day, Year		20d. INJURY OCCURRED WHILE AT <input type="checkbox"/> NOT WHILE WORK <input type="checkbox"/> 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 <u>9-5-53</u> to <u>4-29-59</u> and last saw <sup>her</sup> <sub>him</sub> alive on <u>3-29-59</u> Death occurred at _____ m on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree or title) <u>James M. Myers MD</u>		22b. ADDRESS <u>Rolla, Mo</u>	22c. DATE SIGNED <u>4-3-59</u>
23a. BURIAL, CREMATION, RE-MOVAL (Specify) <u>BURIAL</u>	23b. DATE <u>April 4, 1959</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Pilot Knob Cemetery</u>	23d. LOCATION (City, town, or county) (State) <u>South of Rolla Mo</u>
24. FUNERAL DIRECTOR <u>Lee Johnson</u> ADDRESS <u>Newburg Mo</u>		25. DATE RECD. BY LOCAL REG. <u>May 20, 1959</u>	26. REGISTRAR'S SIGNATURE <u>Nadine L. Stoll</u>

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

All diseases in Part I must be causally related.

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 *Lee Johnson* .....  
Licensed Embalmer No. *3392*

P. O. Address *Newburg*

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.