

t. Health,  
& Welfare  
s. Public  
th Service

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

59-020199  
STATE FILE NUMBER

FILED MAY 19 1959 Registration District No. 360 Primary Registration District No. 6225 Registrar's No. 78

S. 300  
v. 1-57

1. PLACE OF DEATH a. COUNTY <b>Vernon</b>		2. USUAL RESIDENCE (Where deceased lived <sup>State</sup> <del>in</del> <sup>State</sup> <del>in</del> residence before admission) a. STATE <b>Missouri</b> b. COUNTY <b>St. Clair</b>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>Washington</b>		c. CITY OR TOWN <b>Osceola</b>	
Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (IF NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>Nevada State Hosp.</b>		Length of stay in lb <b>#3 0-2-1</b>	
d. STREET ADDRESS <b>Unknown</b>		Reside on Farm <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Sue</b> Middle <b>Bell</b> Last <b>Elkins</b>		4. DATE OF DEATH Month <b>5-</b> Day <b>10-</b> Year <b>1959</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> 3 WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>1875</b>
9. AGE (In years, 100 birthday) <b>81</b>		IF UNDER 1 YEAR Months <b>0</b> Days <b>0</b>	IF UNDER 24 HRS. Hours <b>0</b> Min. <b>0</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Unknown</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Unknown</b>	11. BIRTHPLACE (City and state or country) <b>Osceola Mo.</b>
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		13a. FATHER'S NAME <b>Ben Elkins</b>	
13b. MOTHER'S MAIDEN NAME <b>Unknown</b>		14. NAME OF HUSBAND OR WIFE <b>XX X</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>Unknown</b>		16. SOCIAL SECURITY NO. <b>Unknown</b>	17. INFORMANT <b>Admission Papers</b> 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) <b>Coronary Vessel Disease</b>			INTERVAL BETWEEN ONSET AND DEATH <b>Years</b>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <b>Artheromatous Sclerosis</b>			<b>Years</b>
DUE TO (c) <b>Senil dementia</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <b>Senil dementia</b>			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	
21. I attended the deceased from <b>9-9-59</b> to <b>5-10-59</b> and last saw her <sup>her</sup> <del>her</del> alive on <b>5-9-59</b> Death occurred at <b>5:45 A.M.</b> on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE <b>George Esker, M.D.</b> (Degree or title)		22b. ADDRESS <b>Nevada, Mo.</b>	22c. DATE SIGNED <b>5-10-59</b>
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE <b>5/14/59</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Osceola</b>	23d. LOCATION (City, town, or county) (State) <b>Osceola Mo</b>
24. FUNERAL DIRECTOR <b>Goodrich Funeral Home</b> <b>Goodrich</b>		ADDRESS <b>Osceola, Mo.</b>	25. DATE RECD. BY LOCAL REG. <b>5-13-1959</b>
26. REGISTRAR'S SIGNATURE <b>Anna E. Jurey</b>			

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE  
MEDICAL CERTIFICATION

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.

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 *Paul J. Quastone* .....

Licensed Embalmer No. *3990* .....

P. O. Address *Orwell, Va* .....

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.