

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

59-020282  
STATE FILE NUMBER

FILED JUN 22 1959

Registration District No. 1 Primary Registration District No. 3000 Registrar's No. 185

V. S. 300  
Rev. 1-57

1. PLACE OF DEATH a. COUNTY <b>Adair</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Missouri</b> b. COUNTY <b>Adair</b>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>Kirksville</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <b>Kirksville</b> Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>305 W. Normal</b>		Length of stay in 1b <b>00/13 d</b>	d. STREET ADDRESS (If outside, give location) <b>305 W. Normal</b> Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <b>Guy</b> Middle <b>Marion</b> Last <b>Speaks</b>			4. DATE OF DEATH Month <b>June</b> Day <b>15</b> Year <b>19 59</b>
5. SEX <b>male</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <b>4/5/1912</b>
9. AGE (In years last birthday) <b>47</b>		IF UNDER 1 YEAR Months <b>2</b> Days <b>10</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>factory worker</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Shoe</b>	11. BIRTHPLACE (City and state or country) <b>0</b> <b>Connelville, Mo.</b>
12. CITIZEN OF WHAT COUNTRY? <b>USA</b>		13a. FATHER'S NAME <b>Albert Speaks</b>	
13b. MOTHER'S MAIDEN NAME <b>Manday Marrow</b>		14. NAME OF HUSBAND OR WIFE <b>X X</b>	
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.	17. INFORMANT Address <b>Albert Speaks-Kirksville, Mo.</b>
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>Hepatic cirrhosis</b> DUE TO (b) <b>chronic alcoholism</b> DUE TO (c) _____ Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)			INTERVAL BETWEEN ONSET AND DEATH <b>1 day</b>
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		<b>5811</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.)		
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>6/14/59</b> to <b>6/15/59</b> and last saw him alive on <b>6/14/59</b> Death occurred <b>6/15/59 3:30 P</b> m on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE <b>D. E. Maddox DO</b> (Degree or title)		22b. ADDRESS <b>Kirksville (Mo) Osteopathic Hosp</b>	
22c. DATE SIGNED <b>6/16/59</b>		22d. DATE SIGNED	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE <b>6/16/59</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Rose Cemetery</b>	23d. LOCATION (City, town, or county) (State) <b>Putnam County, Mo.</b>
24. FUNERAL DIRECTOR <b>Davis &amp; Davis</b> ADDRESS <b>Kirksville</b>		25. DATE RECD. BY LOCAL REG. <b>6-18-1959</b>	26. REGISTRAR'S SIGNATURE <b>Doris W. Ratliff</b>

securing the medical certification in the specific manner required by 193.140 MoRS 1949.  
 Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed.  
 Diseases in Part I must be causally related.  
 USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE  
 MEDICAL CERTIFICATION  
 D. E. MADDOX

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 *Donald W. Stegal* .....

Licensed Embalmer No. *4294* .....  
P. O. Address *St. Louis, 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.