

# DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

FILED JUL 1 1959 140

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59-021140

STATE FILE NUMBER

Registration District No. \_\_\_\_\_ Primary Registration District No. \_\_\_\_\_ Registrar's No. \_\_\_\_\_

1. PLACE OF DEATH a. COUNTY <b>Howard</b>			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Missouri</b> COUNTY <b>Howard</b>			
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>Bonne Femme Twp.</b>		Length of stay in 1b <b>7 Months</b>	c. CITY OR TOWN <b>Fayette</b>		Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>Maple Lawn Rest Home</b>		Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <b>S. Moniteau Twp.</b>		Reside on Farm Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>WILLIAM</b> Middle <b>STONE</b> Last <b>WHITE</b>			4. DATE OF DEATH Month <b>JUNE</b> Day <b>23</b> Year <b>1959</b>			
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <b>2/12/1869</b>	9. AGE (last birthday) <b>90</b>	IF UNDER 1 YEAR Months _____ Days _____ Hours _____ Min. _____ IF UNDER 24 HR	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Farming</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Self Employed</b>	11. BIRTHPLACE (City and state or country) <b>Lexington Kentucky</b>		12. CITIZEN OF WHAT COUNTRY <b>U.S.A.</b>	
13a. FATHER'S NAME <b>Durrett V. White</b>		13b. MOTHER'S MAIDEN NAME <b>Sallie Arvin</b>		14. NAME OF HUSBAND OR WIFE <b>Annie Crews</b>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, _____ or unknown) (If yes, give war or dates of service) <b>No.</b>	16. SOCIAL SECURITY NO. <b>None</b>	17. INFORMANT Address <b>Mrs Margaret McKee Fayette, Missou ouri</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>Cerebral Embolus</b> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <b>Chronic Arteriosclerosis</b> DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown					INTERVAL BETWEEN ONSET AND DEATH <b>Immediate</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 _____ a.m. _____ p.m. Month, Day, Year _____						
20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" 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>6-23-59</b> to <b>6-23-59</b> and last saw her/him live on <b>6-23-59</b> Death occurred at <b>11 AM</b> on the date stated above, and to the best of my knowledge, from the causes stated.						
22a. SIGNATURE <i>Walter G. ...</i> (Degree or title)			22b. ADDRESS <i>Fayette Mo</i>		22c. DATE SIGNED <b>6-25-59</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE <b>6/25/1959</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Walnut Ridge Cemetery</b>		23d. LOCATION (City, town, or county) <b>Fayette, Missouri</b>	(State)	
24. FUNERAL DIRECTOR <b>Ronald A. ...</b>		ADDRESS <b>Fayette, Mo.</b>	25. DATE RECD. BY LOCAL REG. <b>6-25-59</b>	26. REGISTRAR'S SIGNATURE <i>Mary K. Shell</i>		

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

JUL 1 1959

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**STATEMENT BY LICENSED EMBALMER**

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by

~~one~~ by \_\_\_\_\_, Student Embalmer No. \_\_\_\_\_

working under my personal supervision.

Student \_\_\_\_\_

Signature of Student Embalmer

Signed

*Ralph A. Carr*

Licensed Embalmer No. 334

P. O. Address Jayette

Note: The above **MUST BE SIGNED BY THE LICENSED EMBALMER** in his **OWN HANDWRITING** (Failure to do 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.