

DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

59-021976

FILED JUL 13 1959

159

4249

45

STATE FILE NUMBER

Registration District No. _____ Primary Registration District No. _____ Registrar's No. _____

1. PLACE OF DEATH a. COUNTY Jefferson b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Hillsboro Length of stay in 1b 2 Yrs c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Cedar Grove Nursing H. Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri COUNTY St. Francois c. CITY OR TOWN Flat River, Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/> d. STREET ADDRESS (If outside, give location) Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>													
3. NAME OF DECEASED (Type or print) First Middle Last ISSAC JEFFERSON REVELLE			4. DATE OF DEATH Month Day Year July 1, 1959														
5. SEX Male	6. COLOR OR RACE White	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH Jan-21-1881	9. AGE (last birthday) 78	<table border="1" style="width: 100%; border-collapse: collapse;"> <tr> <th colspan="2">IF UNDER 1 YEAR</th> <th colspan="2">IF UNDER 24 HR</th> </tr> <tr> <td>Months</td> <td>Days</td> <td>Hours</td> <td>Min.</td> </tr> <tr> <td style="text-align: center;">5</td> <td style="text-align: center;">9</td> <td></td> <td></td> </tr> </table>	IF UNDER 1 YEAR		IF UNDER 24 HR		Months	Days	Hours	Min.	5	9		
IF UNDER 1 YEAR		IF UNDER 24 HR															
Months	Days	Hours	Min.														
5	9																
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer		10b. KIND OF BUSINESS OR INDUSTRY Madison Co. Mo.		11. BIRTHPLACE (City and state or country) U.S.A. 12. CITIZEN OF WHAT COUNTRY													
13a. FATHER'S NAME Andrew Revelle		13b. MOTHER'S MAIDEN NAME Harret Tripp		14. NAME OF HUSBAND OR WIFE Cora Revelle													
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO.		17. INFORMANT Address Clyde Revelle Flat River, Mo.													
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic Heart Disease Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (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 3 1/2 yr +																	
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 WORK <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 1957 to July 1, 1959 and last saw him alive on 6-26-59 Death occurred at 6:15 A.M. on the date stated above, and to the best of my knowledge, from the causes stated.																	
22a. SIGNATURE (Degree or title) John W. Dacke M.D.			22b. ADDRESS 3606 Graven St. Louis		22c. DATE SIGNED 7-6-59												
23a. BURIAL, CREMATION, REMOVAL (Specify) removal		23b. DATE 7-1-59	23c. NAME OF CEMETERY OR CREMATORY Revelle Family Ceme. Madison Co. Mo.		23d. LOCATION (City, town, or county) (State)												
24. FUNERAL DIRECTOR ADDRESS Murphy L. Sparks Flat River, Mo.		25. DATE RECD. BY LOCAL REG. 7-8-59		26. REGISTRAR'S SIGNATURE (Oleta B. Barber) Sep													

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by _____ or by _____, Student Embalmer No. _____ working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed Murphy Sparks
Licensed Embalmer No. 4256
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.