

Health,
Welfare
Public
Service

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

59-022506
STATE FILE NUMBER

FILED JUN 22 1959 Registration District No. 390 Primary Registration District No. 4447 Registrar's No.

300
-57

1. PLACE OF DEATH a. COUNTY Randolph		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY Randolph	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Higbee Mo		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN Higbee Mo. Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION At home		Length of stay in 1b	d. STREET ADDRESS (If outside, give location) 0880 G Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>

3. NAME OF DECEASED (Type or print) First Selma Middle Alida Last Simms			4. DATE OF DEATH Month June Day 16 Year 1959		
---	--	--	--	--	--

5. SEX Female	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 31 1882	9. AGE (In years last birthday) 77 IF UNDER 1 YEAR: Months Days Hours Min. IF UNDER 24 HRS.	
-------------------------	----------------------------------	---	--	--	--

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House Wife	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and state or country) Iowa	12. CITIZEN OF WHAT COUNTRY? U. S. A
--	-----------------------------------	---	--

13a. FATHER'S NAME Nelson Solberg	13b. MOTHER'S MAIDEN NAME Sarah Johnson	14. NAME OF HUSBAND OR WIFE Deceased
---	---	--

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 Mrs Lillian Hicken Higbee 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) Medullary Failure		INTERVAL BETWEEN ONSET AND DEATH 4 1/2 hr 7 days unknown
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) Thrombotic Encephalomalacia	
	DUE TO (c) Advanced Arteriosclerosis	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input 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 6-9-59 to 6-16-59 and last saw her alive on 6-16-59 Death occurred at 4:32 P m on the date stated above; and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Name and title) Geo Y. Brohmson, M.D.	22b. ADDRESS Higbee	22c. DATE SIGNED 6-19-59
---	-------------------------------	------------------------------------

23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE June 18 1959	23c. NAME OF CEMETERY OR CREMATORY City	23d. LOCATION (City, town, or county) (State) Higbee Mo
--	----------------------------------	---	---

24. FUNERAL DIRECTOR ADDRESS Burton Funeral Home Higbee Mo	25. DATE RECD. BY LOCAL REG. June 19-59	26. REGISTRAR'S SIGNATURE Joe W Burton
--	---	--

(Licensed Embalmer's Statement on Reverse Side)

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

Licensed Embalmer No.....

P. O. Address.....

**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.**