

# RI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

## 59-024044

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Registrar's No. 161

STATE FILE NUMBER

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|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------|----------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| 1. PLACE OF DEATH<br>a. COUNTY <u>Andrain</u>                                                                                                                                                                                                                                                                    |                                                                                          |                                                                                                                                                             |                                                       | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <u>Missouri</u> b. COUNTY <u>Andrain</u> |                                                                          |                                                                      |                                                                                                                                                                                 |
| b. CITY (If outside corporate limits, give TOWNSHIP only)<br><u>Mexico</u>                                                                                                                                                                                                                                       |                                                                                          |                                                                                                                                                             | Length of stay in lb<br><u>3 days</u>                 |                                                                                                                                            | c. CITY OR TOWN <u>Centralia</u>                                         |                                                                      | Inside Limits<br>Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>                                                                                            |
| c. FULL NAME OF (If NOT in hospital, give location)<br>HOSPITAL OR INSTITUTION <u>Andrain County Hospital</u>                                                                                                                                                                                                    |                                                                                          |                                                                                                                                                             |                                                       | Inside Limits<br>Yes <input type="checkbox"/> No <input type="checkbox"/>                                                                  |                                                                          | d. STREET ADDRESS (If outside, give location)<br><u>R. 7. D. # 1</u> |                                                                                                                                                                                 |
| 3. NAME OF DECEASED (Type or print)<br>First <u>Elizabeth</u> Middle <u>-</u> Last <u>Younger</u>                                                                                                                                                                                                                |                                                                                          |                                                                                                                                                             |                                                       | 4. DATE OF DEATH<br>Month <u>Aug</u> Day <u>1</u> Year <u>1959</u>                                                                         |                                                                          |                                                                      |                                                                                                                                                                                 |
| 5. SEX<br><u>Female</u>                                                                                                                                                                                                                                                                                          | 6. COLOR OR RACE<br><u>White</u>                                                         | 7. Married <input type="checkbox"/> Never Married <input type="checkbox"/><br>Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/> | 8. DATE OF BIRTH<br><u>April 20-1874</u>              | 9. AGE (last birthday)<br><u>85</u>                                                                                                        | IF UNDER 1 YEAR<br>Months <u>3</u> Days <u>11</u>                        | IF UNDER 24 HR<br>Hours <u></u> Min. <u></u>                         |                                                                                                                                                                                 |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><u>Housewife</u>                                                                                                                                                                                                  |                                                                                          |                                                                                                                                                             | 10b. KIND OF BUSINESS OR INDUSTRY<br><u>Housewife</u> |                                                                                                                                            | 11. BIRTHPLACE (City and state or country)<br><u>Andrain County, Mo.</u> |                                                                      |                                                                                                                                                                                 |
| 12. CITIZEN OF WHAT COUNTRY<br><u>U.S.A.</u>                                                                                                                                                                                                                                                                     |                                                                                          |                                                                                                                                                             |                                                       |                                                                                                                                            |                                                                          |                                                                      |                                                                                                                                                                                 |
| 13. FATHER'S NAME<br><u>Geo. M. Wright</u>                                                                                                                                                                                                                                                                       |                                                                                          |                                                                                                                                                             | 13b. MOTHER'S MARDEN NAME<br><u>Minerva Sims</u>      |                                                                                                                                            |                                                                          | 14. NAME OF HUSBAND OR WIFE<br><u>Deceased</u>                       |                                                                                                                                                                                 |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)<br><u>No</u>                                                                                                                                                                                            |                                                                                          |                                                                                                                                                             | 16. SOCIAL SECURITY NO.<br><u>None</u>                |                                                                                                                                            | 17. INFORMANT<br><u>Ancil Wright, Centralia, Mo.</u>                     |                                                                      |                                                                                                                                                                                 |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>myocardial ischemic</u><br>DUE TO (b) <u>malnutrition</u><br>DUE TO (c) <u></u><br>Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. |                                                                                          |                                                                                                                                                             |                                                       |                                                                                                                                            |                                                                          |                                                                      | INTERVAL BETWEEN ONSET AND DEATH                                                                                                                                                |
| 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.<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown |
| 19. WAS AUTOPSY PERFORMED?<br>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<br>Hour <u></u> Month, Day, Year <u></u><br>a.m. <u></u> p.m. <u></u>                                                                                                                                                                                                                        |                                                                                          |                                                                                                                                                             |                                                       |                                                                                                                                            |                                                                          |                                                                      |                                                                                                                                                                                 |
| 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 <u>7-29-59</u> to <u>8-1-59</u> and last saw her alive on <u>8-1-59</u><br>Death occurred at <u>10:42</u> P on the date stated above, and to the best of my knowledge, from the causes stated.                                                                                  |                                                                                          |                                                                                                                                                             |                                                       |                                                                                                                                            |                                                                          |                                                                      |                                                                                                                                                                                 |
| 22a. SIGNATURE (Doctor or title)<br><u>V.B. Doshette, D.O.</u>                                                                                                                                                                                                                                                   |                                                                                          |                                                                                                                                                             |                                                       | 22b. ADDRESS<br><u>Mexico, Mo.</u>                                                                                                         |                                                                          | 22c. DATE SIGNED<br><u>8-3-59</u>                                    |                                                                                                                                                                                 |
| 23a. BURIAL CREMATION, REMOVAL (Specify)<br><u>Burial</u>                                                                                                                                                                                                                                                        | 23b. DATE<br><u>8/3/59</u>                                                               | 23c. NAME OF CEMETERY OR CREMATORY<br><u>Centralia Cemetery</u>                                                                                             |                                                       | 23d. LOCATION (City, town, or county) (State)<br><u>Centralia, Missouri</u>                                                                |                                                                          |                                                                      |                                                                                                                                                                                 |
| 24. FUNERAL DIRECTOR<br><u>Paul J. Ballou, Centralia, Mo</u>                                                                                                                                                                                                                                                     |                                                                                          |                                                                                                                                                             |                                                       | 25. DATE RECD. BY LOCAL REG.<br><u>Aug 3-1959</u>                                                                                          |                                                                          | 26. REGISTRAR'S SIGNATURE<br><u>Blanche Neely</u>                    |                                                                                                                                                                                 |

(Licensed Embalmer's Statement on Reverse Side)

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

MS APR 6 1930

**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 Paul G. Baller.

Licensed Embalmer No. 4206

P. O. Address Centralia,

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.