

RI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

59-024137

FILED VS JUL 20 1959 38

3006

310

STATE FILE NUMBER

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

1. PLACE OF DEATH a. COUNTY <b>Boone</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Missouri</b> b. COUNTY <b>VERNON</b>			
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>COLUMBIA</b>			Length of stay in 1b <b>2600</b>		c. CITY OR TOWN <b>SHELDON</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>U. of Mo. MEDICAL CENTER HOSP.</b>				Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location) <b>ROUTE 2</b>	
3. NAME OF DECEASED (Type or print) First <b>ELSIE</b> Middle <b>YOSS</b> Last <b>LAND</b>						4. DATE OF DEATH Month <b>JULY</b> Day <b>13</b> Year <b>1959</b>	
5. SEX <b>FEMALE</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>11-20-1917</b>	
9. AGE (last birthday) <b>41</b>		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>At Home</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>FAIRMOUNT, IOWA</b>		11. BIRTHPLACE (City and state or country) <b>U. S. A.</b>	
13a. FATHER'S NAME <b>B.A. YOSS</b>				13b. MOTHER'S MAIDEN NAME <b>ELIZABETH HEARMAYER</b>		14. NAME OF HUSBAND OR WIFE <b>LAWRENCE LAND</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. <b>482-28-4990</b>		17. INFORMANT <b>Medical Center Hosl. Record</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>ACUTE PULMONARY EDEMA</b> DUE TO (b) <b>MITRAL STENOSIS</b> DUE TO (c) <b>RHEUMATIC HEART DISEASE</b>							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. <input type="checkbox"/> Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> Unknown
19. WAS AUTOPSY PERFORMED? YES <input checked="" 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 _____ a.m. _____ p.m. Month, Day, Year _____							
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 <b>7/6/59</b> to <b>7/13/59</b> and last saw her alive on <b>7/13/59</b> Death occurred at <b>1140 A</b> m on the date stated above, and to the best of my knowledge, from the causes stated.							
22a. SIGNATURE <i>J. J. [Signature]</i> (Degree or title) <b>M.D.</b>				22b. ADDRESS <b>Univ of Mo. Med Center</b>		22c. DATE SIGNED <b>7/13/59</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>ROYAL</b>		23b. DATE <b>7-14-59</b>		23c. NAME OF CEMETERY OR CREMATORY <b>MO. MONROE I.A.</b>		23d. LOCATION (City, town, or county) (State)	
24. FUNERAL DIRECTOR <b>Baker Funeral Service</b> ADDRESS <b>Columbia MO.</b>				25. DATE RECD. BY LOCAL REG. <b>July 14 1959</b>		26. REGISTRAR'S SIGNATURE <b>Mrs R E Palmer</b>	

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

*Tom McHarg*

Licensed Embalmer No. 4067

P. O. Address Columb

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.