

RI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

FILED VS AUG 1 0 1959

59-024349

STATE FILE NUMBER

Registration District No. 46 Primary Registration District No. 4063 Registrar's No. 25

1. PLACE OF DEATH a. COUNTY <b>Caldwell</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Missouri</b> b. COUNTY <b>Jackson</b>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>Hamilton</b>		Length of stay in 1b <b>8 Mo.</b>	c. CITY OR TOWN <b>Kansas City</b> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (IF NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>Hamilton Nursing Home</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print) First <b>Frank</b> Middle <b>Ernest</b> Last <b>Axon</b>			4. DATE OF DEATH Month <b>July</b> Day <b>31</b> Year <b>1959</b>		
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5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <b>10/19/80</b>	9. AGE (last birthday) <b>78</b>	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HR Hours Min.
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Ret. Farmer</b>	10b. KIND OF BUSINESS OR INDUSTRY <b>Farming</b>	11. BIRTHPLACE (City and state or country) <b>Caldwell Co. Mo.</b>	12. CITIZEN OF WHAT COUNTRY <b>U.S.A.</b>
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13a. FATHER'S NAME <b>Eli Axon</b>	13b. MOTHER'S MAIDEN NAME <b>Catherine Howden</b>	14. NAME OF HUSBAND OR WIFE <b>Dora Lou Axon</b>
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>NO</b>	16. SOCIAL SECURITY NO. <b>491-22-0156</b>	17. INFORMANT <b>Leland Axon</b> Address <b>Hamilton, Mo.</b>
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18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY:		INTERVAL BETWEEN ONSET AND DEATH <b>2 weeks</b>  <b>10 years</b>
IMMEDIATE CAUSE (a)	<b>Cerebral thrombosis</b>	
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) <b>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) <b>Parkinson's Disease</b>	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
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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.)
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20c. TIME OF INJURY Hour <b>4 AM</b> 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 <b>Hamilton Caldwell Mo.</b>	COUNTY <b>Caldwell</b>	STATE <b>Mo.</b>
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21. I attended the deceased from <b>Jan 1959</b> to <b>July 31, 1959</b> and last saw him alive on <b>7-30-59</b> Death occurred at <b>4 AM</b> on the date stated above, and to the best of my knowledge, from the causes stated.	
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22a. SIGNATURE <b>Frank R. Daley, MD.</b> (Degree or title)	22b. ADDRESS <b>Hamilton Mo.</b>	22c. DATE SIGNED <b>8/1/1959</b>
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23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE <b>8/1/1959</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Rosehill Cemetery</b>	23d. LOCATION (City, town, or county) <b>Breckenridge, Mo.</b>
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24. FUNERAL DIRECTOR <b>Morris A. Bram</b> ADDRESS <b>Hamilton, Mo.</b>	25. DATE RECD. BY LOCAL REG. <b>Aug 4 - 59</b>	26. REGISTRAR'S SIGNATURE <b>Blodys Jones</b>
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(Licensed Embalmer's Statement on Reverse Side)

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 Morris A. B...

Licensed Embalmer No. 391

P. O. Address Jamil

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.