

# DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

FILED VS AUG 12 1959

59-024365

Registration District No. 47 Primary Registration District No. 3008 Registrar's No. 207

STATE FILE NUMBER

<b>1. PLACE OF DEATH</b>		<b>2. USUAL RESIDENCE</b> (Where deceased lived. If institution: Residence before admission)	
a. COUNTY <b>CALLAWAY</b>	b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>FULTON</b>	a. STATE <b>MISSOURI</b> COUNTY <b>LINCOLN</b>	c. CITY OR TOWN <b>ELSBERRY</b>
		Length of stay in 1b <b>4 yrs.</b>	Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>STATE HOSPITAL NO. 1</b>		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"/>

<b>3. NAME OF DECEASED</b> (Type or print)			<b>4. DATE OF DEATH</b>			
First <b>JOE</b>	Middle <b>B.</b>	Last <b>HERRING</b>	Month <b>AUGUST</b>	Day <b>5</b>	Year <b>1959</b>	

5. SEX <b>MALE</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>11-22-1894</b>	9. AGE (last birthday) <b>64</b>	IF UNDER 1 YEAR Months _____ Days _____	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>FARMER</b>	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and state or country) <b>MISSOURI</b>	12. CITIZEN OF WHAT COUNTRY <b>U.S.A.</b>
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13a. FATHER'S NAME <b>JOE B. HERRING</b>	13b. MOTHER'S MAIDEN NAME <b>MARIAH DIXON</b>	14. NAME OF HUSBAND OR WIFE <b>EDNA WILLIS HERRING</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>UNKNOWN</b>	16. SOCIAL SECURITY NO. <b>UNKNOWN</b>	17. INFORMANT ADDRESS <b>STATE HOSPITAL NO. 1, FULTON, 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: IMMEDIATE CAUSE (a) <b>SUFFOCATION DUE TO ASPIRATED FOREIGN BODY</b>		INTERVAL BETWEEN ONSET AND DEATH
DUE TO (b) <b>HUNTINGTON'S CHOREA</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
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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.)
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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"/>
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20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	20f. CITY, TOWN, OR LOCATION <b>137</b>	COUNTY _____ STATE _____
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21. I attended the deceased from **6-9-1955** to **8-5-1959** and last saw ~~her~~ <sup>him</sup> alive on **8-5-1959**  
 Death occurred at **8:00 a.m.** on the date stated above, and to the best of my knowledge, from the causes stated.

22. SIGNATURE <i>Erwin Leonhardt</i> (Doctor or other) <b>Erwin Leonhardt, M.D.</b>	22b. ADDRESS <b>State Hospital No. 1</b>	22c. DATE SIGNED <b>8-5-59</b>
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23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>	23b. DATE <b>8-7-59</b>	23c. NAME OF CEMETERY OR CREMATORY <b>ELSBERRY CEMETERY</b>	23d. LOCATION (City, town, or county) (State) <b>ELSBERRY MO.</b>
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24. FUNERAL DIRECTOR ADDRESS <b>MAUPIN FUNERAL HOME FULTON MO.</b>	25. DATE RECD. BY LOCAL REG. <b>Aug. 5-1959</b>	26. REGISTRAR'S SIGNATURE <i>Maritta Lawrence</i>
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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 Marshall C. Black

Licensed Embalmer No. 4712

P. O. Address Fulton

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to conform 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.