

RI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

59-924370

FILED VS JUL 29 1959

Registration District No. 47 Primary Registration District No. 3008 Registrar's No. 195

STATE FILE NUMBER

1. PLACE OF DEATH a. COUNTY <u>Callaway</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Mo.</u> b. COUNTY <u>Callaway</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Fulton</u>		c. CITY OR TOWN <u>Fulton</u>	
Length of stay in 1b <u>13 years</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>Callaway Memorial Hosp.</u>		d. STREET ADDRESS (If outside, give location) <u>708 Court</u>	
Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	

3. NAME OF DECEASED (Type or print) First <u>James</u> Middle <u>B.</u> Last <u>Muir</u>			4. DATE OF DEATH Month <u>July</u> Day <u>21</u> Year <u>1959</u>				
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <u>3-22-74</u>	9. AGE (last birthday) <u>85</u>	IF UNDER 1 YEAR Months <u> </u> Days <u> </u>	IF UNDER 24 HR Hours <u> </u> Min. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Street Car and Bus</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Operator</u>		11. BIRTHPLACE (City and state or country) <u>Callaway Co.</u>		12. CITIZEN OF WHAT COUNTRY <u>U. S. A.</u>	

13a. FATHER'S NAME <u>James W. Muir</u>		13b. MOTHER'S MAIDEN NAME <u>Mary E. Callaway</u>		14. NAME OF HUSBAND OR WIFE <u>Mollie Smith Muir</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>490-096292</u>		17. INFORMANT <u>Mollie S. Muir</u>	
				Address <u>708 Court</u> <u>Fulton, Mo.</u>	

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CEREBRO VASCULAR ACCIDENT.</u>		INTERVAL BETWEEN ONSET AND DEATH <u>1 WEEK</u>
DUE TO (b) <u>ARTERIOSCLEROSIS</u>		
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (c) _____		

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>Diabetes mellitus, Nephrosclerosis</u>			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		
--	--	--	--	--	--

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.)			
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 <u>July 15, 1959</u> to <u>July 21, 1959</u> and last saw her alive on <u>July 21, 1959</u> Death occurred at <u>5:30</u> p.m. on the date stated above, and to the best of my knowledge, from the causes stated.			

22. SIGNATURE (Degree or title) <u>James E. Hill M.D.</u>		22b. ADDRESS <u>Fulton, Mo</u>		22c. DATE SIGNED <u>7-22-59</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE <u>July 23, 1959</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Riverview</u>	23d. LOCATION (City, town, or county) (State) <u>Jefferson City, Mo.</u>		

24. FUNERAL DIRECTOR ADDRESS <u>Wallace Funeral Home Fulton, Mo</u>		25. DATE RECD. BY LOCAL REG. <u>22 July 1959</u>	26. REGISTRAR'S SIGNATURE <u>Marta Lawrence</u>	
--	--	---	--	--

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

8961

2 10 1958

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

A. R. Massey

Licensed Embalmer No. 4996

P. O. Address Fulton, N

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.