

RI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

59-024383

FILED VS JUL 21 1959

Registration District No. 49 Primary Registration District No. 5774 Registrar's No. 13

STATE FILE NUMBER

DED

1. PLACE OF DEATH a. COUNTY <u>CAMDEN</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MISSOURI</u> b. COUNTY <u>CAMDEN</u>			
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>CLIMAX SPRINGS</u>		Length of stay in lb <u>Life</u>		c. CITY OR TOWN <u>CLIMAX SPRINGS</u>		Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>Adair Township</u>			Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <u>2 miles North</u>		Reside on Farm Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>MYRNA THOMAS WAINER</u>				4. DATE OF DEATH Month Day Year <u>July 8, 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>Feb 20, 1907</u>	9. AGE (last birthday) <u>52</u>	IF UNDER 1 YEAR Months Days Hours Min. <u>4 18</u>	IF UNDER 24 HR
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>FARMING</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>FARM-GROWER</u>		11. BIRTHPLACE (City and state or country) <u>Climax Springs, Mo.</u>		12. CITIZEN OF WHAT COUNTRY <u>U. S. A.</u>	
13a. FATHER'S NAME <u>James J. Wainier</u>			13b. MOTHER'S MAIDEN NAME <u>Lucinda Newman</u>		14. NAME OF HUSBAND OR WIFE <u>Mayme Wainier</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>No</u>		17. INFORMANT <u>Mayme Wainier Edwards, Mo.</u> Address		
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>Respiratory paralysis, partial</u>			
DUE TO (b)				<u>Intracranial pressure</u>			
DUE TO (c)				<u>Spongiblastoma, left temporal</u>			
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			
<u>abscess right hip; chronic cystitis +</u>				<u>pyelonephritis</u>			
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 checked="" 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>1957</u> to <u>July 5, 1959</u> and last saw him <u>July 5, 1959</u> Death occurred at <u>2:00 p.</u> m on the date stated above, and to the best of my knowledge, from the causes stated.							
22a. SIGNATURE <u>Emilio Desousa</u> (Degree or title)				22b. ADDRESS <u>Warsaw, Mo.</u>		22c. DATE SIGNED <u>7-10-59</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City, town, or county)		(State)	
<u>Burial July, 1959</u>	<u>July, 1959</u>	<u>Deerity Cemetery</u>		<u>Edwards Benton Co. Mo</u>			
24. FUNERAL DIRECTOR <u>John F. Reser</u> ADDRESS <u>Warsaw, Mo</u>		25. DATE RECD. BY LOCAL REG. <u>7-13-59</u>	26. REGISTRAR'S SIGNATURE <u>Alma Eldred</u>				

(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 John J. Reese

Licensed Embalmer No. 4094

P. O. Address Warsaw

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.