

# RI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

# 59-024484

## FILED VS JUL-31 1959

STATE FILE NUMBER

 Registration District No. \_\_\_\_\_ Primary Registration District No. 3012 Registrar's No. 13

<b>1. PLACE OF DEATH</b> a. COUNTY <u>Clay</u> b. CITY (if outside corporate limits, give TOWNSHIP only) OR TOWN <u>Excelsior Springs</u> Length of stay in city or town <u>less than 1 day</u> c. FULL NAME OF (if NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>Excelsior Springs, Hospital</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>			<b>2. USUAL RESIDENCE</b> (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Clay</u> c. CITY OR TOWN <u>Excelsior Springs</u> 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"/>		
<b>3. NAME OF DECEASED</b> (Type or print) First Middle Last <u>Charles Eldon Essig Jr.</u>			<b>4. DATE OF DEATH</b> Month Day Year <u>July 23 1959</u>		
<b>5. SEX</b> <u>Male</u>	<b>6. COLOR OR RACE</b> <u>White</u>	<b>7. Married</b> <input type="checkbox"/> <b>Never Married</b> <input checked="" type="checkbox"/> <b>Widowed</b> <input type="checkbox"/> <b>Divorced</b> <input type="checkbox"/>	<b>8. DATE OF BIRTH</b> <u>7-23-1959</u>	<b>9. AGE (last birthday)</b> IF UNDER 1 YEAR: Months _____ Days _____ IF UNDER 24 HR: Hours <u>3</u> Min. _____	<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) _____
<b>10b. KIND OF BUSINESS OR INDUSTRY</b> _____		<b>11. BIRTHPLACE</b> (City and state or country) <u>Excelsior Springs, Mo.</u>		<b>12. CITIZEN OF WHAT COUNTRY</b> <u>USA</u>	
<b>13a. FATHER'S NAME</b> <u>Charles Eldon Essig</u>		<b>13b. MOTHER'S MAIDEN NAME</b> <u>Mary Katherine Parks</u>		<b>14. NAME OF HUSBAND OR WIFE</b> <u>None</u>	
<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) (If yes, give war or dates of service) <u>NO</u>		<b>16. SOCIAL SECURITY NO.</b> <u>none</u>		<b>17. INFORMANT</b> Address _____ Mo. _____ <u>Charles Eldon Essig, Excelsior Springs,</u>	
<b>18. CAUSE OF DEATH</b> (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Anoxia</u> DUE TO (b) <u>Failure of lungs to expand</u> DUE TO (c) <u>Prematurity</u> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.					INTERVAL BETWEEN ONSET AND DEATH <u>3 hours</u>  <u>3 hours.</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 checked="" type="checkbox"/> No <input type="checkbox"/> Unknown
<b>19. WAS AUTOPSY PERFORMED?</b> YES <input type="checkbox"/> NO <input type="checkbox"/>	<b>20a. ACCIDENT</b> <input type="checkbox"/> <b>SUICIDE</b> <input type="checkbox"/> <b>HOMICIDE</b> <input type="checkbox"/>	<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in PART I or PART II of item 18.) _____			
<b>20c. TIME OF INJURY</b> Hour _____ a.m. _____ p.m. Month, Day, Year _____					
<b>20d. INJURY OCCURRED WHILE AT WORK</b> <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		<b>20e. PLACE OF INJURY</b> (e.g., in or about home, farm, factory, street, office bldg., etc.) _____		<b>20f. CITY, TOWN, OR LOCATION</b> COUNTY _____ STATE _____	
<b>21. I attended the deceased from</b> <u>birth - 7/23/59</u> to <u>7/23/59</u> and last saw him alive on <u>7/23/59</u> Death occurred at <u>2:30 p.m.</u> on the date stated above, and to the best of my knowledge, from the causes stated.					
<b>22a. SIGNATURE</b> (Degree or title) <u>Ralph L. Nicholson, M.D.</u>			<b>22b. ADDRESS</b> <u>116 South St. Excelsior Springs, Mo.</u>		<b>22c. DATE SIGNED</b> <u>7/24/59</u>
<b>23a. BURIAL, CREMATION, REMOVAL</b> (Specify) <u>Burial</u>		<b>23b. DATE</b> <u>7-24-1959</u>	<b>23c. NAME OF CEMETERY OR CREMATORY</b> <u>Crown Hill</u>	<b>23d. LOCATION</b> (City, town, or county) (State) <u>Excelsior Springs, Missouri</u>	
<b>24. FUNERAL HOME, ADDRESS</b> <u>Richard Funeral Home, Inc. Excelsior Springs, Missouri</u>			<b>25. DATE RECD. BY LOCAL REG.</b> <u>7-26-59</u>	<b>26. REGISTRAR'S SIGNATURE</b> <u>Baroline Hutchings</u>	

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

*Ralph Van Landingham*

Licensed Embalmer No. 4009

*Folsom Springs, Va*  
P. O. Address \_\_\_\_\_

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.

