

FRI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

59-025745

FILED VS AUG 12 1959

Registration District No. 267 Primary Registration District No. 4256 Registrar's No. 32

STATE FILE NUMBER

1. PLACE OF DEATH a. COUNTY <u>Johnson</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> - b. COUNTY <u>Johnson</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Holden</u>		c. CITY OR TOWN <u>R.P.D. Holden Mo</u>	
Length of stay in 1b <u>2 weeks</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>Holden Hospital</u>		d. STREET ADDRESS (If outside, give location) <u>Route #1</u>	
Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		Reside on Farm Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	

3. NAME OF DECEASED (Type or print) First Middle Last <u>BARBARA ANNA GEARY</u>			4. DATE OF DEATH Month Day Year <u>August 6 1959</u>			
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</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>2-14-85</u>	9. AGE (last birthday) <u>74</u>	IF UNDER 1 YEAR	IF UNDER 24 HR
				Months	Days	Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Homemaker</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u>		11. BIRTHPLACE (City and state of country) <u>Johnson Co Mo</u>		12. CITIZEN OF WHAT COUNTRY <u>USA</u>	
13a. FATHER'S NAME <u>Erving Green Mason</u>			13b. MOTHER'S MAIDEN NAME <u>Clara Nichle</u>		14. NAME OF HUSBAND OR WIFE <u>Harrie Geary</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.		17. INFORMANT Address <u>Minnie Fisher, Holden Mo</u>			

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 <u>3 weeks</u>
IMMEDIATE CAUSE (a) <u>Cerebral Hemorrhage</u>			
DUE TO (b) _____			
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.			
DUE TO (c) <u>Hypertensive C.V. Disease</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

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 July 16 1959 to Aug 6 59 and last saw her him alive on Aug 6 1959
 Death occurred at 6 PM on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) <u>Kelly Rawlins M.D.</u>		22b. ADDRESS <u>Holden Mo</u>		22c. DATE SIGNED <u>8/7/59</u>
23a. BURIAL, CREMATION OR DISPOSAL (Specify) <u>Burial</u>	23b. DATE <u>Aug 9 1959</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Holden Cemetery</u>	23d. LOCATION (City, town, or county) <u>Holden Mo</u>	
24. FUNERAL DIRECTOR ADDRESS <u>Canada's Klipp Holden Mo</u>		25. DATE RECD. BY LOCAL REG. <u>aug 8, 1959</u>	25. REGISTRAR'S SIGNATURE <u>Mrs W J Redford</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 M. J. Casaday

Licensed Embalmer No. 343

P. O. Address Holden, Va

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.