

RI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

59-025844

FILED VS JUL 27 1959

STATE FILE NUMBER

Registration District No. 184 Primary Registration District No. 3038 Registrar's No. 73

DED

1. PLACE OF DEATH a. COUNTY <u>Linn</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Linn</u>			
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Brookfield</u>			Length of stay in 1b <u>2 mo. 21 days</u>		c. CITY OR TOWN <u>Brookfield</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>Doctor's Hospital</u>				Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location) <u>503 Pettijohn</u>	
3. NAME OF DECEASED (Type or print) First <u>Emma</u> Middle <u>Main</u> Last <u>Main</u>				4. DATE OF DEATH Month <u>July</u> Day <u>17</u> Year <u>1959</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. Married <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>		8. DATE OF BIRTH <u>9/26/1893</u>	9. AGE (last birthday) <u>65</u>		IF UNDER 1 YEAR Months <u>9</u> Days <u>22</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Shoe worker</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>Brown Shoe Factory, Hart, Macon Co., Mo.</u>		11. BIRTHPLACE (City and state or country) <u>U. S. A.</u>		
13a. FATHER'S NAME <u>Henry E. Main</u>			13b. MOTHER'S MAIDEN NAME <u>Mary E. McDaniel</u>			14. NAME OF HUSBAND OR WIFE <u>- none -</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>495-07-0198</u>		17. INFORMANT <u>Ray Kimbal, Brookfield, 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
IMMEDIATE CAUSE (a) <u>Acute left congestive heart failure</u>							<u>2 weeks</u>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.							
DUE TO (b) <u>Wide spread malignant metastasis</u>							<u>2 mo. 21 days</u>
DUE TO (c) <u>Adenocarcinoma of liver and gallbladder.</u>							<u>7 months</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 <u> </u> e.m. <u> </u> p.m. <u> </u>		Month, Day, Year <u> </u>					
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>December 1959</u> , to <u>July 17, 1959</u> and last saw her/him alive on <u>July 17, 1959</u> Death occurred at <u> </u> m on the date stated above, and to the best of my knowledge, from the causes stated.							
22a. SIGNATURE <u>R. L. Ryals</u> (Degree or title) <u>Dr. R. L. Ryals</u>				22b. ADDRESS <u>Brookfield, Missouri</u>		22c. DATE SIGNED <u>7-17-59</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>		23b. DATE <u>July 19, 1959</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Rose Hill Cemetery</u>		23d. LOCATION (City, town, or county) (State) <u>Brookfield, Missouri</u>		
24. FUNERAL DIRECTOR <u>Hill Funeral Home, Brookfield, Mo.</u>			25. DATE RECD. BY LOCAL REG. <u>7-21-59</u>		26. REGISTRAR'S SIGNATURE <u>Katharine Johnson Dep.</u>		

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

REC- 21 500

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by _____, Student Embalmer No. _____, or by _____, Student Embalmer No. _____, working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed Gerald I Wacker

Licensed Embalmer No. 4123

P. O. Address Brown

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.