

RI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

FILED VS JUL 21 1959

59-026191

STATE FILE NUMBER 96

Registration District No. _____ Primary Registration District No. 278 Registrar's No. 3054

1. PLACE OF DEATH a. COUNTY PIKE		2. USUAL RESIDENCE (Where deceased lived if institution: Residence before admission) a. STATE Mo. b. COUNTY PIKE	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN LOUISIANA	Length of stay in 1b 19 DAYS	c. CITY OR TOWN BOWLING GREEN	Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION PIKE CO. HOSP.	Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) R.F.D. TWO	Reside on Farm Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>

3. NAME OF DECEASED (Type or print) First NANCY Middle FLORENCE Last BRIGGS			4. DATE OF DEATH Month JULY Day 12 Year 1959	
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input checked="" type="checkbox"/>	8. DATE OF BIRTH JAN. 5, 1881	9. AGE (last birthday) 78
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSE WIFE		10b. KIND OF BUSINESS OR INDUSTRY HOME	11. BIRTHPLACE (City and state or country) MONT BOMERY CITY, MO.	12. CITIZEN OF WHAT COUNTRY U.S.A.
13a. FATHER'S NAME ISRAEL BUTLER		13b. MOTHER'S MAIDEN NAME AMANDA WILBURN		13c. NAME OF HUSBAND OR WIFE _____
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. NONE	17. INFORMANT Address MRS. CLARENCE COUCH, BOWLING GREEN	

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 24 hours
IMMEDIATE CAUSE (a) Pulmonary Hemorrhage		
DUE TO (b) Pneumonia and pulmonary abscess DUE TO (c) _____ Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	4 weeks	
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

19. WAS AUTOPSY PERFORMED? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	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 _____	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 1954 to 7/12/59 and last saw her ^{her} _{him} alive on 7/11/59 Death occurred at 6:58 A.M. on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree or title) Charles H. Luellen		22b. ADDRESS M.D. Louisiana, Missouri	22c. DATE SIGNED 7/15/59

23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	23b. DATE JULY 14, 1959	23c. NAME OF CEMETERY OR CREMATORY RIVERVIEW CEM.	23d. LOCATION (City, town, or county) LOUISIANA, MO.
24. FUNERAL DIRECTOR GEO. M. COLLIER, LOUISIANA, MO	25. DATE RECD. BY LOCAL REG. July 15, 1959	26. REGISTRAR'S SIGNATURE Berniece Collier	

(Licensed Embalmer's Certificate 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 Geo. M. Call

Licensed Embalmer No. 2839

P. O. Address Louisiana

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.