

RI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

59-026239

FILED VS AUG 17 1959 94

3056

171

STATE FILE NUMBER

IDED

Registration District No.

Primary Registration District No.

Registrar's No.

1. PLACE OF DEATH a. COUNTY <u>Randolph</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Mo.</u> b. COUNTY <u>Monroe</u>			
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Moberly</u>		Length of stay in 1b <u>2 weeks</u>		c. CITY OR TOWN <u>Madison</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>Woodland</u>				d. STREET ADDRESS <u>Route 2</u>		(If outside, give location) Reside on Farm Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Odessa</u> Middle <u>Elizabeth</u> Last <u>Sims</u>				4. DATE OF DEATH Month <u>August</u> Day <u>3</u> Year <u>1959</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>Caucasian</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>4/15/84</u>	9. AGE (last birthday) <u>75</u>	IF UNDER 1 YEAR Months <u>3</u> Days <u>18</u>		IF UNDER 24 HR Hours <u></u> Min. <u></u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (City and state or country) <u>Monroe County, Mo.</u>		12. CITIZEN OF WHAT COUNTRY <u>USA</u>	
13a. FATHER'S NAME <u>John T. Wooden</u>		13b. MOTHER'S MAIDEN NAME <u>Fannie Hulen</u>		14. NAME OF HUSBAND OR WIFE <u>Clarence E. Sims</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>488-40-1726</u>		17. INFORMANT <u>Clarence E. Sims, Rte 2, Madison, Mo</u>			
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>Arterial Fibrillation</u> DUE TO (b) <u>Coronary Sclerosis</u> DUE TO (c) <u></u> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.						INTERVAL BETWEEN ONSET AND DEATH <u>3 days</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>Basal Ovarian Cyst (operated for) July 30 '59</u>						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 checked="" 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> Month, Day, Year <u></u> a.m. <u></u> p.m. <u></u>							
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.) <u></u>		20f. CITY, TOWN, OR LOCATION <u></u>		COUNTY <u></u>	STATE <u></u>
21. I attended the deceased from <u>July 27 '59</u> to <u>Aug 2 '59</u> and last saw her alive on <u>Aug 2 '59</u> Death occurred at <u>12:50 PM Aug 3 '59</u> on the date stated above, and to the best of my knowledge, from the causes stated.							
22a. SIGNATURE <u>Will Henry Jones</u> (Degree or title)				22b. ADDRESS <u>Moberly Mo</u>		22c. DATE SIGNED <u>Aug 4 '59</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE <u>Aug. 5, '59</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Centralia</u>		23d. LOCATION (City, town, or county) (State) <u>Centralia, Mo.</u>	
24. FUNERAL DIRECTOR <u>Bill Go. Henderson</u>		ADDRESS <u>Centralia, Missouri</u>		25. DATE RECD. BY LOCAL REG. <u>8-5-59</u>		REGISTRAR'S SIGNATURE <u>Deborah</u>	

(Licensed Embalmer's Statement on Reverse Side)

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

AUG 17 1959

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 Bill J. Meador

Licensed Embalmer No. 4876
P. O. Address Centerville, Mo.

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.