

R DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

59-027990

FILED VS SEP 8 1959

Registration District No. 1 Primary Registration District No. 3000 Registrar's No. 262 STATE FILE NUMBER

1. PLACE OF DEATH				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)			
a. COUNTY <u>Adair</u>		b. CITY (If outside corporate limits, give TOWNSHIP only) OR <u>Kirksville</u>		a. STATE <u>Mo.</u>		b. COUNTY <u>Adair</u>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>Laughlin Hospital</u>		Length of stay in 1b		c. CITY OR TOWN <u>Kirksville</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS <u>403 E. Illinois</u>		(If outside, give location) Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
3. NAME OF DECEASED				4. DATE OF DEATH			
First <u>Noah</u>		Middle <u>Phillo</u>		Last <u>Motter</u>		Month <u>Aug.</u> Day <u>19,</u> Year <u>1959</u>	
5. SEX <u>M</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>3/27/1882</u>	9. AGE (last birthday) <u>77</u>	IF UNDER 1 YEAR Months <u></u> Days <u></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>Retired Farmer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Farm</u>		11. BIRTHPLACE (City and state or country) <u>Adair County, Mo.</u>		12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>	
13a. FATHER'S NAME <u>Joseph Motter</u>			13b. MOTHER'S MAIDEN NAME <u>Carrie Shoop</u>		14. NAME OF HUSBAND OR WIFE <u>Mabel Willis</u>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>489-42-0859</u>		17. INFORMANT Address <u>Mrs. Mabel Motter, Kirksville, 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>CONGESTIVE HEART FAILURE</u>						<u>6-8 hours</u>	
DUE TO (b) <u>L. VENTRICULAR HYPERTROPHY</u>						<u>UNKNOWN</u>	
DUE TO (c) <u></u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition (given in PART I (a)) <u>BENIGN PROSTATIC HYPERTROPHY -</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 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> a.m. <u></u> p.m. <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 <u></u> STATE <u></u>	
21. I attended the deceased from <u>8-12-59</u> to <u>8-19-59</u> and last saw him alive on <u>8-18-59</u> Death occurred at <u>4:30 A</u> m on the date stated above, and to the best of my knowledge, from the causes stated.							
22a. SIGNATURE <u>Paul Laughlin</u> (Degree or title)				22b. ADDRESS <u>Kirksville, Mo.</u>		22c. DATE SIGNED <u>8-19-59</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE <u>8/21/59</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Mulberry Cemetery</u>		23d. LOCATION (City, town, or county) <u>Adair County, Mo.</u>		(State)	
24. FUNERAL DIRECTOR <u>Paul W. Ratliff</u> ADDRESS <u>Kirksville, Mo.</u>			25. DATE RECD. BY LOCAL REG. <u>8-29-1959</u>		26. REGISTRAR'S SIGNATURE <u>Doris W. Ratliff</u>		

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

EARL LANGELIN, JR., D.O.

201009 4-13
L. LANGELIN

201009 4-13
L. LANGELIN

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 George W. Davall

Licensed Embalmer No. 4799
P. O. Address Cuba

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.

12-11-09