

RI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

59-028026

FILED VS SEP 8 1959

Registration District No. _____

Primary Registration District No. _____

Registrar's No. *82*

STATE FILE NUMBER

DED

1. PLACE OF DEATH a. COUNTY Atchison				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY Holt			
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Fairfax			Length of stay in 1b 6 weeks		c. CITY OR TOWN Mound City		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Community Hospital			Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location) Yes <input type="checkbox"/> No <input type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First GOLDA Middle LEONE Last MAY				4. DATE OF DEATH Month Sept. Day 2 Year 1959			
5. SEX Female	6. COLOR OR RACE White	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH 10/9/1895	9. AGE (last birthday) 63	IF UNDER 1 YEAR Months _____ Days _____		IF UNDER 24 HR Hours _____ Min. _____
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY In the home		11. BIRTHPLACE (City and state or country) Mound City, Missouri		12. CITIZEN OF WHAT COUNTRY USA	
13a. FATHER'S NAME James Lester Browning			13b. MOTHER'S MAIDEN NAME Florida Schultz		14. NAME OF HUSBAND OR WIFE Allen May		
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. Unknown		17. INFORMANT Frost Browning, Tarkio, Missouri Address _____		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute CARDIAC Decompensation						INTERVAL BETWEEN ONSET AND DEATH 3 wks	
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) Advanced Atherosclerotic HEART Disease						DUE TO (c) _____	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) Carcinoma of Cervix Uteri, Carcinoma RT. Breast						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? 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 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 1, 1955 to Sept 2, 1959 and last saw her alive on Sept 2, 1959 Death occurred at 5 A.M. on the date stated above, and to the best of my knowledge, from the causes stated.							
22a. SIGNATURE J. J. Sweeney (Degree or title) M.D.				22b. ADDRESS O Rego, Mo.		22c. DATE SIGNED 9-2-59	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 9/4/1959	23c. NAME OF CEMETERY OR CREMATORY Memorial Park Cemetery		23d. LOCATION (City, town, or county) (State) St. Joseph, Missouri		
24. FUNERAL DIRECTOR James H. Crawford Mound City, Mo. ADDRESS _____				25. DATE RECD. BY LOCAL REG. Sept 5, 1959		26. REGISTRAR'S SIGNATURE Harvin J. Schaefer	

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

OCT 30 1958

SEP 29 1958

OCT 14 1958

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

James H. Crawford

Licensed Embalmer No. 4796

P. O. Address Mound Cr.

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.