

DEPARTMENT OF HEALTH - STANDARD CERTIFICATE OF DEATH

59-028043

FILED VS SEP 4 1959

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STATE FILE NUMBER

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

1. PLACE OF DEATH a. COUNTY Audrain b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Mexico Length of stay in 1b 10 dys c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Audrain County Hospital Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri COUNTY Montgomery c. CITY OR TOWN Wellsville Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/> d. STREET ADDRESS (If outside, give location) RR #1 Upper Lutre Twp. Reside on Farm Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First KATE Middle ELIZABETH Last LONG			4. DATE OF DEATH Month Aug. Day 24 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 2/28/1894	9. AGE (last birthday) 65 IF UNDER 1 YEAR: Months 5 Days 26 IF UNDER 24 HR: Hours _____ Min. _____			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House wife		10b. KIND OF BUSINESS OR INDUSTRY at Home		11. BIRTHPLACE (City and state or country) Wellsville, Mo.			
12. CITIZEN OF WHAT COUNTRY U. S. A.		13a. FATHER'S NAME Charles Trowbridge		13b. MOTHER'S MAIDEN NAME Emma Oakes			
14. NAME OF HUSBAND OR WIFE H.M. Long		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. _____		17. INFORMANT Address J. M. Long, Wellsville, Mo					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Respiratory paralysis Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) Muscular dystrophy DUE TO (c) _____				INTERVAL BETWEEN ONSET AND DEATH 1 week 1 1/2 years			
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 _____ Month, Day, Year _____ a.m. p.m.		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			
20g. STATE		21. I attended the deceased from 8-14-59 to 8-24-59 and last saw her alive on 8-24-59 . Death occurred at 10:34 A.M. on the date stated above, and to the best of my knowledge, from the causes stated.					
22a. SIGNATURE (Degree or title) Harold D. Long M.D.			22b. ADDRESS Missouri Mo				
22c. DATE SIGNED 8-26-59		23a. BURIAL, CREMATION, REMOVAL (Specify) Burial					
23b. DATE Aug. 26, 1959	23c. NAME OF CEMETERY OR CREMATORY Wellsville City		23d. LOCATION (City, town, or county) (State) Wellsville, Mo				
24. FUNERAL DIRECTOR ADDRESS B. B. Wells Wellsville, Mo		25. DATE RECD. BY LOCAL REG. Aug. 26-1959		26. REGISTRAR'S SIGNATURE Blanche Neely			

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 Howard F. Snyder

Licensed Embalmer No. 4494

P. O. Address Wellsville

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.