

DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

59-028088

FILED VS SEP 15 1959

Registration District No. 27 Primary Registration District No. 3005 Registrar's No. 110

STATE FILE NUMBER

1. PLACE OF DEATH a. COUNTY <u>BATES -</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MO</u> b. COUNTY <u>BATES</u>				
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>BUTLER.</u>		Length of stay in 1b <u>23 YRS</u>		c. CITY OR TOWN <u>BUTLER -</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		
c. FULL NAME OF HOSPITAL OR INSTITUTION <u>405 WTS Scott</u>			Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location) <u>405 WTS Scott</u>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>OLIVER</u> Middle <u>ALBERT</u> Last <u>DELL</u>				4. DATE OF DEATH Month <u>SEPT</u> Day <u>2</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>MAR 19 - 1892 - 67</u>		9. AGE (last birthday)	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>INT DECORATOR.</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>PRINTING</u>		11. BIRTHPLACE (City and state or country) <u>MICHIGAN</u>		12. CITIZEN OF WHAT COUNTRY <u>USA</u>	
13a. FATHER'S NAME <u>DELL</u>			13b. MOTHER'S MAIDEN NAME <u>UNKNOWN -</u>			14. NAME OF HUSBAND OR WIFE <u>Nell Dell</u>		
15. WAS DECEASED EVER IN U.S. ARMED SERVICES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>NO</u>			16. SOCIAL SECURITY NO. <u>509-20-2508</u>		17. INFORMANT <u>Nell Dell - Butler Mo</u> Address			
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>Coronary Thrombosis</u>							<u>immediate</u>	
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <u>Arteriosclerotic heart</u>								
DUE TO (c) <u>diets.</u>								
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.) <u>None</u>				
20c. TIME OF INJURY Hour <u></u> Month, Day, Year <u>None</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		STATE
21. I attended the deceased from _____, to _____, and last saw her him alive on <u>9/2/59</u> . Death occurred at <u>H:40A</u> on the date stated above, and to the best of my knowledge, from the causes stated.								
22a. SIGNATURE (Deceased or title) <u>Douglas Howard MD</u>				22b. ADDRESS <u>Butler, Mo</u>			22c. DATE SIGNED <u>9/4/59</u>	
23a. BURIAL, CREATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE <u>9-5-59</u>	23c. NAME OF CEMETERY OR CREMATORY <u>OXHILL</u>		23d. LOCATION (City, town, or county) <u>BUTLER - MO</u>		23e. (State)	
24. FUNERAL DIRECTOR <u>Culver Underwood - Butler Mo</u>				25. DATE RECD. BY LOCAL REG. <u>Sept. 4 - 1959</u>		26. REGISTRAR'S SIGNATURE <u>Randall K...</u>		

(Licensed Embalmer's Statement 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

John D. Anderson

Licensed Embalmer No. 3585

P. O. Address Butler 8

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.