

# RI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

59-028352

FILED VS SEP 2 1959 47

Registration District No. 47 Primary Registration District No. 3008 Registrar's No. 224

STATE FILE NUMBER

1. PLACE OF DEATH a. COUNTY <b>Callaway County</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Missouri</b> b. COUNTY <b>Cooper</b>				
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>Fulton.</b>		Length of stay in 1b <b>2 1/2 yrs</b>		c. CITY OR TOWN <b>Pilot Grove</b>		Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>		
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>State Hospital # 1</b>			Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location) <b>R. R.</b>		Reside on Farm Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>BESSIE</b> Middle <b>WOOLERY</b> Last <b>READ</b>				4. DATE OF DEATH Month <b>Aug</b> Day <b>23</b> Year <b>1959</b>				
5. SEX <b>FEMALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>		8. DATE OF BIRTH <b>11-10-81</b>	9. AGE (last birthday) <b>78</b>	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) <b>Housewife</b>			10b. KIND OF BUSINESS OR INDUSTRY <b>HOME</b>		11. BIRTHPLACE (City and state or country) <b>Cooper County-Mo.</b>		12. CITIZEN OF WHAT COUNTRY <b>USA.</b>	
13a. FATHER'S NAME <b>T.F. Woolery</b>			13b. MOTHER'S MAIDEN NAME <b>Elizabeth Wilks</b>		14. NAME OF HUSBAND OR WIFE <b>Unknown</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>			16. SOCIAL SECURITY NO. <b>DK</b>		17. INFORMANT Address <b>Hosp. Records Fulton Mo</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Lung - bronchopneumonia</b>							INTERVAL BETWEEN ONSET AND DEATH <b>3 days</b>	
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.) DUE TO (b) <b>Chronic Brain Syndrome</b>								
DUE TO (c) _____								
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <b>Inanition</b>						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 checked="" type="checkbox"/> NO <input 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.		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 <b>8-23-59</b> Death occurred at <b>4:55</b> a.m. on the date stated above, and to the best of my knowledge, from the causes stated.								
22a. SIGNATURE <b>B. Blachman MD</b> (Degree or title)				22b. ADDRESS <b>407 COURT ST</b>		22c. DATE SIGNED <b>23 Aug 59</b>		
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE <b>8/25/59</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Mount Nebo</b>		23d. LOCATION (City, town, or county) <b>Pilot Grove</b>		STATE <b>Mo.</b>		
24. FUNERAL DIRECTOR <b>Hallace Funeral Home Fulton, Mo</b> ADDRESS			25. DATE RECD. BY LOCAL REG. <b>Aug 23, 1959</b>		26. REGISTRAR'S SIGNATURE <b>Maretha Lawrence</b>			

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 Denzil E. Browning

Licensed Embalmer No. 2724

P. O. Address Fulton

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.