

RI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

59-028539

EILED VS AUG 24 1959 2

Registration District No. \_\_\_\_\_ Primary Registration District No. 4148 Registrar's No. 116

STATE FILE NUMBER

1. PLACE OF DEATH a. COUNTY <u>Cooper</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Cooper</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>atterville</u>		Length of stay in lb <u>87 yrs</u>	c. CITY OR TOWN <u>atterville</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>✓</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <u>✓</u> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print) First Middle Last <u>JUD-ERNEST-GOLLADAY</u>			4. DATE OF DEATH Month Day Year <u>Aug 18, 1959</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>wh</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>June 11, 1872</u>	9. AGE (last birthday) <u>87</u>	IF UNDER 1 YEAR	IF UNDER 24 HR
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Merchant</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>same</u>	11. BIRTH PLACE (City and state or country) <u>atterville mo</u>	12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>		

13a. FATHER'S NAME <u>John Bailey Golladay</u>		13b. MOTHER'S MAIDEN NAME <u>Alvira Louise Bidstrup</u>		14. NAME OF HUSBAND OR WIFE <u>Mrs. Hallie Golladay</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>no</u>		16. SOCIAL SECURITY NO. <u>✓</u>		17. INFORMANT Address <u>Mrs. Hallie Golladay, atterville, 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 <u>6 days</u>
IMMEDIATE CAUSE (a) <u>Cerebrovascular Accident</u>			
DUE TO (b) <u>Generalized arteriosclerosis</u>			
DUE TO (c) _____			
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 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 12 Aug 1959 to 8-18-59 and last saw him alive on 12 Aug 1959  
 Death occurred at 7:30p on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) <u>Donald C. Hunter M.D.</u>		22b. ADDRESS <u>Seldia, Mo.</u>		22c. DATE SIGNED <u>18 Aug 1959</u>
23a. BURIAL, CREMATION, OR REMOVAL (Specify) <u>Burial</u>	23b. DATE <u>8/21/59</u>	23c. NAME OF CEMETERY OR CREMATORY <u>I.O.O.F Ceme.</u>	23d. LOCATION (City, town, or county) (State) <u>atterville, mo</u>	

24. FUNERAL DIRECTOR ADDRESS <u>Hays Hunter, atterville, mo.</u>		25. DATE RECD. BY LOCAL REG. <u>8/20/59</u>	26. REGISTRAR'S SIGNATURE <u>D. Hooper</u>
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DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

SEP 8 1967

MAY 27 1968

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 Robert L. Paint

Licensed Embalmer No. 4069

P. O. Address Pilot Gro

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.