

FRI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

FILED VS AUG 24 1959

59-028636

STATE FILE NUMBER

Registration District No. 115-116 Primary Registration District No. 3020 Registrar's No. 177

1. PLACE OF DEATH a. COUNTY <u>Franklin</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Franklin</u>				
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Washington</u>		Length of stay in lb <u>8 hrs.</u>		c. CITY OR TOWN <u>Robertville</u>		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>		
c. FULL NAME OF (If NOT in Hospital, give location) HOSPITAL OR INSTITUTION <u>St. Francis Hospital</u>			Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location) <u>none</u>		Reside on Farm Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>DEBORAH</u> Middle <u>KAY</u> Last <u>FLEMMING</u>				4. DATE OF DEATH Month <u>August</u> Day <u>17</u> Year <u>1959</u>				
5. SEX <u>Female</u>	6. COLOR OR RACE <u>Negro</u>	7. Married <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>		8. DATE OF BIRTH <u>6-26-55</u>	9. AGE (last birthday) <u>4</u>	IF UNDER 1 YEAR Months <u>2</u> Days <u>22</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>none</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>none</u>		11. BIRTHPLACE (City and state or country) <u>Robertville, Mo.</u>		12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>	
13a. FATHER'S NAME <u>William Stevens</u>			13b. MOTHER'S MAIDEN NAME <u>Stella Mae Flemming</u>			14. NAME OF HUSBAND OR WIFE <u>none</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>none</u>		17. INFORMANT Address <u>Mildred Flemming Robertville, Mo.</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>MASSIVE PERITONITIS - P.O. CARDIAC ARREST</u>								INTERVAL BETWEEN ONSET AND DEATH <u>48 hrs??</u>
DUE TO (b) <u>RUPTURED APPENDIX</u>								
DUE TO (c) <u></u>								
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>GANGRENOUS RT. TUBER &amp; Ovary</u>								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 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 <u></u> a.m. <u></u> p.m. <u></u>		Month, Day, Year <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 <u>8-16-59</u> to <u>death</u> and last saw her/him alive on <u>8-17-59</u> Death occurred at <u>7:00</u> <u>p</u> m on the date stated above, and to the best of my knowledge, from the causes stated.								
22a. SIGNATURE (Degree or title) <u>John F. Pearl, M.D.</u>				22b. ADDRESS <u>St. Clair, Mo</u>			22c. DATE SIGNED <u>8-19-59</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE <u>Aug. 20-59</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Mount Calvary Cemetery</u>		23d. LOCATION (City, town, or county) <u>Robertville, Mo.</u>			(State)
24. FUNERAL DIRECTOR ADDRESS <u>Shenwood W. Kitchell St. Clair Mo</u>				25. DATE REGD. BY LOCAL REG. <u>8/20/59</u>		26. REGISTRAR'S SIGNATURE <u>J.P. Widmanny R.P. Widmanny</u>		

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

1966 5 8 967

**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 Sherwood W. Kitchell

Licensed Embalmer No. 3873

P. O. Address St Clair

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.