

RI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

FILED VS SEP 15 1959

59-028689

Registration District No. 120 Primary Registration District No. _____ Registrar's No. 86 STATE FILE NUMBER

1. PLACE OF DEATH a. COUNTY <u>Gentry</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Mo</u> b. COUNTY <u>DeKalb</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>King City</u>		Length of stay in 1b <u>2 Days</u>	c. CITY OR TOWN <u>Clarksdale</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>Office Dr. E.P. Fischer</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) _____ Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print) First <u>CORA</u> Middle <u>E.</u> Last <u>TILLER</u>			4. DATE OF DEATH Month <u>Sept.</u> Day <u>6</u> Year <u>1959</u>		
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</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>Jan. 8 1879</u>	9. AGE (last birthday) <u>80</u> IF UNDER 1 YEAR IF UNDER 24 HR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Housewife</u>	11. BIRTHPLACE (City and state or country) <u>DeKalb Co. Mo.</u>		12. CITIZEN OF WHAT COUNTRY <u>U.S.</u>
13a. FATHER'S NAME <u>Joseph Honn</u>		13b. MOTHER'S MAIDEN NAME <u>Mary Helms</u>		14. NAME OF HUSBAND OR WIFE <u>John Tiller</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 <u>John Tiller, Clarksdale, Mo.</u> Address _____
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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>CIRCULATORY FAILURE</u>		INTERVAL BETWEEN ONSET AND DEATH <u>1 yr.</u> <u>12 hrs.</u> <u>15 yrs</u>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <u>Acute CORONARY Thrombosis</u>		
DUE TO (c) <u>Diabetes Mellitus and Arteriosclerosis</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 checked="" 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 JAN, 1958 to Sept 6, 1959 and last saw her her alive on Sept. 6, 1959
Death occurred at 4:30 P.M. on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE <u>EP Fischer</u> (Degree or title) <u>P.O.</u>	22b. ADDRESS <u>King City, Mo.</u>	22c. DATE SIGNED <u>Sept. 6, 1959</u>
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>	23b. DATE <u>9-6-59</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Memorial Park</u>
24. FUNERAL DIRECTOR <u>Pilcher Funeral Home, Maysville Mo.</u> ADDRESS _____		23d. LOCATION (City, town, or country) (State) <u>St. Joseph, Mo.</u>

25. DATE RECD. BY LOCAL REG. <u>9-8-59</u>	26. REGISTRAR'S SIGNATURE <u>Mrs. L.W. Bare</u>
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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


C. T. Pilcher

Licensed Embalmer No. 3960

P. O. Address Maysville Missouri

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.