

# RI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

59-028709

STATE FILE NUMBER

FILED VS AUG 24 1959

Registration District No. 128 Primary Registration District No. 2000 Registrar's No. 880

IDED

1. PLACE OF DEATH a. COUNTY <b>Greene</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Missouri</b> b. COUNTY <b>Polk</b>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>Springfield</b>		Length of stay in 1b <b>7 Weeks</b>	c. CITY OR TOWN <b>Humansville</b>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>704 S. Kickapoo</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <b>None</b>
Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>			

3. NAME OF DECEASED (Type or print) First Middle Last <b>IDA BELLE CARMICHAEL</b>			4. DATE OF DEATH Month Day Year <b>August 20, 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>23 Dec. 1870</b>	9. AGE (last birthday) <b>88</b>	IF UNDER 1 YEAR Months Days 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>Missouri</b>	12. CITIZEN OF WHAT COUNTRY <b>USA</b>	
13a. FATHER'S NAME <b>Unknown</b>		13b. MOTHER'S MAIDEN NAME <b>Unknown</b>		14. NAME OF HUSBAND OR WIFE <b>Deceased</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>Unknown</b>	17. INFORMANT Address <b>Mrs. Frank Wann Springfield, Mo.</b>	
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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) <b>Cerebral Thrombosis due to</b>			INTERVAL BETWEEN ONSET AND DEATH
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) <b>arteriosclerosis</b>		
	DUE TO (c) <b>Arteriosclerotic heart disease</b>		
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 SUICIDE HOMICIDE <input type="checkbox"/> <input checked="" type="checkbox"/> <input type="checkbox"/>	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.) <b>none</b>
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 2-9-57 to 8/20/59 and last saw her alive on 8-20-59  
Death occurred at 3:00 P.m on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE <b>W.D. Bane, M.D.</b>	(Degree or title)	22b. ADDRESS <b>609 Cherry Springfield, Missouri</b>	22c. DATE SIGNED <b>8/20/59</b>
23a. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE <b>8/22/59</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Humansville Cemetery</b>	23d. LOCATION (City, town, or county) (State) <b>Humansville, Missouri</b>

24. FUNERAL DIRECTOR <b>Beckwith Funeral Home</b>	ADDRESS <b>Humansville, Mo.</b>	25. DATE RECD. BY LOCAL REG. <b>8-21-59</b>	26. REGISTRAR'S SIGNATURE <b>Effie S. Melton</b>
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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 Glen D Williams

Licensed Embalmer No. 4651

P. O. Address Springfield

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.