

RI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

59-028896

FILED VS AUG 31 1959

Registration District No. 41 Primary Registration District No. 3025 Registrar's No. 109

STATE FILE NUMBER

DEED

1. PLACE OF DEATH a. COUNTY <u>Newell</u>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Mo.</u> b. COUNTY <u>Newell</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) <u>West Plains</u>	Length of stay in lb <u>3 yrs</u>	c. CITY OR TOWN <u>West Plains</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 <input checked="" type="checkbox"/>		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <u>515 Locust</u>
		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	

3. NAME OF DECEASED (Type or print) First <u>Ethel E.</u> Middle <u>Martin</u> Last <u>Martin</u>			4. DATE OF DEATH Month <u>7</u> Day <u>7</u> Year <u>1959</u>			
5. SEX <u>2</u>	6. COLOR OR RACE <u>W</u>	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <u>10-9-1890</u>	9. AGE (last birthday) <u>68</u>	IF UNDER 1 YEAR Months <u>8</u> Days <u>28</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>News</u>		10b. KIND OF BUSINESS OR INDUSTRY <input checked="" type="checkbox"/>	11. BIRTHPLACE (City and state of country) <u>West Plains Mo USA</u>		12. CITIZEN OF WHAT COUNTRY <u>USA</u>	

13. FATHER'S NAME <u>Doc Williams</u>		13b. MOTHER'S MAIDEN NAME <u>Leah</u>		14. NAME OF HUSBAND OR WIFE <u>W.C. Martin</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT <u>W.C. Martin, West Plains 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		
IMMEDIATE CAUSE (a) <u>Myocardial failure, decompensation</u>			<u>2 mos.</u>		
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) <u>Fracture pelvis (fall) rt.</u>		<u>8 1/2 mo.</u>		
	DUE TO (c) <u>Senility & dementia</u>		<u>3 mo</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 checked="" type="checkbox"/> No <input type="checkbox"/> Unknown	

19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20a. ACCIDENT <input checked="" 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.) <u>fall in the home (slipped)</u>			
20c. TIME OF INJURY Hour <u></u> s.m. <u></u> p.m. <u></u>	Month, Day, Year <u>3/20/59</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.) <u>3/20/59</u>	20f. CITY, TOWN, OR LOCATION <u>West Plains Mo</u>	COUNTY	STATE
21. I attended the deceased from <u>11:30 A</u> to <u>7-7-59</u> and last saw her <u>7-6-59</u> alive on <u>7-6-59</u> . Death occurred at <u>11:30 A</u> m on the date stated above, and to the best of my knowledge, from the causes stated.				

22a. SIGNATURE <u>Virgil A. Bailey</u> (Degree or title)		22b. ADDRESS <u>West Plains Mo</u>		22c. DATE SIGNED <u>8/24/59</u>
23a. BURIAL, CREMATION, REBURIAL (Specify)	23b. DATE <u>7-10-59</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Oak Lawn</u>	23d. LOCATION (City, town, or county) (State) <u>West Plains Mo</u>	
24. FUNERAL DIRECTOR <u>Coburn's West Plains Mo</u>		25. DATE RECD. BY LOCAL REG. <u>8-27-59</u>	26. REGISTRAR'S SIGNATURE <u>Beatrice Cook</u>	

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

SEP 3 1959

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 *A. A. Roberts*

Licensed Embalmer No. 343

P. O. Address *West 7*

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.