

RI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

59-028905

FILED VS AUG 17 1959

STATE FILE NUMBER

Registration District No. 141 Primary Registration District No. 3025 Registrar's No. 96

DED

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>South Fork</u>		Length of stay in lb <u>4 1/2 yrs</u>		c. CITY OR TOWN <u>South Fork</u>		Inside Limits Yes <input type="checkbox"/> No <input checked="" 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) <input checked="" type="checkbox"/>		Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Kerry Elmer</u> Middle <u>Moore</u> Last <u>Moore</u>				4. DATE OF DEATH Month <u>7</u> Day <u>19</u> Year <u>59</u>				
5. SEX <u>mm</u>	6. COLOR OR RACE <u>W</u>	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>		8. DATE OF BIRTH <u>9-23-1892</u>	9. AGE (last birthday) <u>86</u>	IF UNDER 1 YEAR Months <u>7</u> Days <u>26</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>retired farmer</u>			10b. KIND OF BUSINESS OR INDUSTRY <input checked="" type="checkbox"/>		11. BIRTHPLACE (City and state or country) <u>Avalon Mo U S A</u>		12. CITIZEN OF WHAT COUNTRY <u>U S A</u>	
13a. FATHER'S NAME <u>Mo. Moore</u>			13b. MOTHER'S MAIDEN NAME <u>Mollie Kasper</u>			14. NAME OF HUSBAND OR WIFE <input checked="" type="checkbox"/>		
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. <input checked="" type="checkbox"/>		17. INFORMANT <u>Bill Moore S. Fork Mo</u> Address <u></u>			
18. CAUSE OF DEATH (Enter only one line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial failure</u> DUE TO (b) <u>Chronic Myocarditis</u> DUE TO (c) <u>Hypertension</u> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.							INTERVAL BETWEEN ONSET AND DEATH <u>24 hr</u> <u>year</u> <u>year</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 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> 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>6-7-58</u> to <u>7-18-59</u> and last saw her alive on <u>7-18-59</u> Death occurred at <u>5:40 A.M.</u> on the date stated above, and to the best of my knowledge, from the causes stated.								
22a. SIGNATURE <u>[Signature]</u> (Degree or title) <u>MD</u>				22b. ADDRESS <u>West Plains Mo</u>		22c. DATE SIGNED <u>8/4/59</u>		
23a. BURIAL CREMATION REMOVAL (Specify)		23b. DATE <u>7-22-59</u>	23c. NAME OF CEMETERY OR CREMATORY <u>B. Fork</u>		23d. LOCATION (City, town, or county) (State) <u>B. Fork Mo</u>			
24. FUNERAL DIRECTOR <u>[Signature]</u>		ADDRESS <u>[Address]</u>		25. DATE RECD. BY LOCAL REG. <u>8-13-59</u>		26. REGISTRAR'S SIGNATURE <u>Beatrice Cook</u>		

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

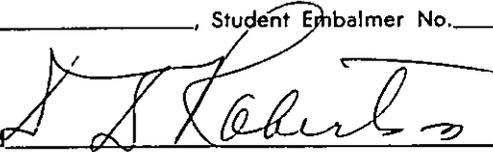
or by _____, Student Embalmer No. _____

working under my personal supervision.

Student _____

Signature of Student Embalmer

Signed



Licensed Embalmer No. 3487

P. O. Address West Hill

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.