

MARI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

59-029616

FILED VS AUG 18 1959 / 170

Registration District No. _____ Primary Registration District No. 3033 Registrar's No. 122

STATE FILE NUMBER

INDEXED
DOCUMENT
MEDICAL CERTIFICATION
BY AFFIDAVIT OF

1. PLACE OF DEATH a. COUNTY <u>Laclede</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Laclede</u>			
b. CITY (If outside corporate limits, give TOWNSHIP only) <u>Lebanon</u>		Length of stay in 1b <u>6 days</u>		c. CITY OR TOWN <u>Grovespring</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>Wallace Hospital</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (if outside give location) <u>Rural Route</u>		Reside on Farm Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Ada</u> Middle <u>Howell</u> Last _____				4. DATE OF DEATH Month <u>Aug.</u> Day <u>8</u> Year <u>1959</u>			
5. SEX <u>F</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>7/29/1896</u>	9. AGE (last birthday) <u>63</u>	IF UNDER 1 YEAR Months _____ Days _____ Hours _____ Min. _____	IF UNDER 24 HR 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>-</u>		11. BIRTHPLACE (City and state or country) <u>Wright Co. Mo. U.S.A.</u>		12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>	
13a. FATHER'S NAME <u>Thomas Simmons</u>			13b. MOTHER'S MAIDEN NAME <u>Nancy Fincher</u>		14. NAME OF HUSBAND OR WIFE <u>Laurence Howell</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>Miss Verba Howell Grovespring Mo.</u> Address _____			
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>Ulcemia</u>						INTERVAL BETWEEN ONSET AND DEATH <u>2 weeks</u>	
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.		DUE TO (b) <u>Hypertensive cardio-vascular</u>		DUE TO (c) <u>Renal disease</u>		<u>10 yrs.</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 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. _____	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>1957</u> to <u>Aug 7, 1959</u> and last saw her alive on <u>Aug 7, 1959</u> Death occurred at <u>7:10 P.M.</u> on the date stated above, and to the best of my knowledge from the causes stated.							
22a. SIGNATURE (Degree or title) <u>W. Carrington M.D. Lebanon, Mo.</u>				22b. ADDRESS		22c. DATE SIGNED <u>8-13-59</u>	
23a. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE <u>8/10/59</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Mrs. Bride Cemetery Laclede Co. Mo.</u>		23d. LOCATION (City, town, or county) <u>Laclede Co. Mo.</u>			
24. FUNERAL DIRECTOR <u>Dorsey M. Howe Lebanon Mo.</u>			25. DATE RECD. BY LOCAL REG. <u>8-14-1959</u>		26. REGISTRAR'S SIGNATURE <u>Hella L. May</u>		

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 Dorsey M. How

Licensed Embalmer No. 4222

P. O. Address Lebanon

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.