

RI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

59-029733

FILED VS SEP 1 1959

Registration District No. 187 Primary Registration District No. 3040 Registrar's No. 214

STATE FILE NUMBER

DEED

1. PLACE OF DEATH a. COUNTY <u>Livingston</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Mo.</u> b. COUNTY <u>Livingston</u>			
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Chillicothe</u>		Length of stay in 1b <u>2 yrs.</u>		c. CITY OR TOWN <u>Chillicothe</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>119 Wilson St.</u>			Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <u>119 Wilson St.</u>			Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <u>NANNIE</u> Middle <u>KINNEY</u> Last <u>WHITE</u>			4. DATE OF DEATH Month <u>August</u> Day <u>23</u> Year <u>1959</u>				
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</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>9-11-75</u>	9. AGE (last birthday) <u>83</u>	IF UNDER 1 YEAR Months _____ Days _____	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>home</u>		11. BIRTHPLACE (City and state or country) <u>Livingston Co., Mo.</u>		12. CITIZEN OF WHAT COUNTRY <u>USA</u>
13a. FATHER'S NAME <u>Peter Massengale</u>			13b. MOTHER'S MAIDEN NAME <u>Mary Hicklin</u>		14. NAME OF HUSBAND OR WIFE <u>William L. White</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>Harold E. White</u> Address <u>1304 34th St. Des Moines, Ia.</u>			
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>Cardiovascular renal disease</u>							INTERVAL BETWEEN ONSET AND DEATH <u>3 years</u>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>Hypostatic pneumonia</u>						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 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 checked="" 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>1947</u> to <u>1959</u> and last saw her <u>alive</u> on <u>22 Aug. 1959</u> Death occurred at <u>12:55</u> <u>P</u> m on the date stated above, and to the best of my knowledge, from the causes stated.							
22a. SIGNATURE (Degree or title) <u>Charles M. Grace, M.D.</u>				22b. ADDRESS <u>Chillicothe, Mo.</u>		22c. DATE SIGNED <u>24 Aug. 1959</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>burial</u>	23b. DATE <u>Aug. 25, 1959</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Edgewood</u>		23d. LOCATION (City, town, or county) <u>Chillicothe, Mo.</u>		23e. STATE <u>Mo.</u>	
24. FUNERAL DIRECTOR <u>NORMAN FUNERAL HOME-Chillicothe, Mo.</u>			25. DATE RECD. BY LOCAL REG. <u>Aug/24/59</u>		26. REGISTRAR'S SIGNATURE <u>Frances B Neill</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 John Bolin

Licensed Embalmer No. 5035

P. O. Address Chillicothe,

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.