

RI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

59-029893

FILED VS SEP 14 1959 251

3048

206

STATE FILE NUMBER

INDEXED

1. PLACE OF DEATH a. COUNTY Nodaway				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri COUNTY Nodaway						
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Maryville		Length of stay in 1b 6 days		c. CITY OR TOWN Conception Jct.		Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>				
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION St. Francis Hospital			Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location) 5 miles west		Reside on Farm Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First HARRY Middle ADAM Last COULTER				4. DATE OF DEATH Month 9 Day 4 Year 59						
5. SEX Male	6. COLOR OR RACE White	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>		8. DATE OF BIRTH 3/25/73	9. AGE (last birthday) 86	IF UNDER 1 YEAR Months <input type="checkbox"/> Days <input type="checkbox"/> Hours <input type="checkbox"/> Min. <input type="checkbox"/>		IF UNDER 24 HR Hours <input type="checkbox"/> Min. <input type="checkbox"/>		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer-retired			10b. KIND OF BUSINESS OR INDUSTRY Own account		11. BIRTHPLACE (City and state or country) Ohio		12. CITIZEN OF WHAT COUNTRY USA			
13a. FATHER'S NAME H. T. Coulter			13b. MOTHER'S MAIDEN NAME Sarah B. Miller			14. NAME OF HUSBAND OR WIFE Susan Wright Coulter			dec.	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO. none		17. INFORMANT Mrs. Alec Jensen, Conception Jct., Mo.			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) Acute Cardiac Dilatation								INTERVAL BETWEEN ONSET AND DEATH Sudden		
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.		DUE TO (b) Chronic Myocarditis & Decompensation						DUE TO (c)		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) Arthritis and Anemia						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 <input type="checkbox"/> a.m. <input type="checkbox"/> 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 Aug 26, 1959 to 9/4/59 and last saw DEK him alive on 9-3-59 Death occurred at 3:00 A. m on the date stated above, and to the best of my knowledge, from the causes stated.										
22a. SIGNATURE W.R. Jackson (Degree or title) M. D.				22b. ADDRESS Maryville, Missouri				22c. DATE SIGNED 9/6/59		
23a. BURIAL, CREMATION, REMOVAL (Specify) burial		23b. DATE 9/6/59	23c. NAME OF CEMETERY OR CREMATORY Miriam		23d. LOCATION (City, town, or county) (State) Maryville, Missouri					
24. FUNERAL DIRECTOR Price Funeral Home, Maryville, Mo.				25. DATE RECD. BY LOCAL REG. 9-6-59		26. REGISTRAR'S SIGNATURE Bess Holt				

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

SEP 17 1955

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 Clay M. Price

Licensed Embalmer No. 1829

P. O. Address Marshall

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.