

R DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

59-030093

STATE FILE NUMBER

Registration District No. 294 Primary Registration District No. 3056 Registrar's No. 191

1. PLACE OF DEATH a. COUNTY <u>Randolph</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Randolph</u>			
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Moberly</u>		Length of stay in 1b <u>53 Yrs.</u>		c. CITY OR TOWN <u>Moberly</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>421 S. 5th</u>			Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <u>421 S. 5th</u>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>MARY</u> Middle <u>NANNIE</u> Last <u>VICTOR</u>			4. DATE OF DEATH Month <u>AUG.</u> Day <u>30</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>2015-1865</u>	9. AGE (last birthday) <u>94</u>	IF UNDER 1 YEAR Months <u> </u> Days <u> </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>Housewife</u>			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (City and state or country) <u>Macon, Mo.</u>	12. CITIZEN OF WHAT COUNTRY <u>USA</u>	
13a. FATHER'S NAME <u>Jacob Engle</u>			13b. MOTHER'S MAIDEN NAME <u>Virginia Given</u>			14. NAME OF HUSBAND OR WIFE	
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>Virginia Victor</u>		Address <u>Moberly</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>Myocarditis</u>						INTERVAL BETWEEN ONSET AND DEATH <u>months</u>	
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <u> </u>						DUE TO (c) <u> </u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>Fractured hip, Senility, arterio-sclerosis.</u>						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.) <u>Fell over afternoon on her front Nov. 17/55</u>					
20c. TIME OF INJURY Hour <u> </u> Month <u>11</u> Day <u>18</u> Year <u>55</u> a.m. <u> </u> p.m. <u> </u>		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.) <u>Home</u>		20f. CITY, TOWN, OR LOCATION <u>Moberly</u> COUNTY <u> </u> STATE <u> </u>	
21. I attended the deceased from <u>Nov 17/55</u> to <u>Aug 30/59</u> and last saw her alive on <u>July 17/59</u>				Death occurred at <u>9:25 pm</u> on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE <u>An L E. Huber MD</u> (Degree or title)			22b. ADDRESS <u>Moberly Mo</u>			22c. DATE SIGNED <u>9/10/59</u> (State)	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE <u>Sept. 1, 1959</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Oakland</u>		23d. LOCATION (City, town, or county) <u>Moberly</u>			
24. FUNERAL DIRECTOR <u>Mahan Funeral Service</u> ADDRESS <u>Moberly</u>			25. DATE RECD. BY LOCAL REG. <u>9-1-59</u>		26. REGISTRAR'S SIGNATURE <u>Deablow</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 A. Green

Licensed Embalmer No. 3815

P. O. Address Woford, N.C.

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.