

FRI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

59-031101

FILED VS AUG 31 1959

Registration District No. 317 Primary Registration District No. 500 Registrar's No. 2298 STATE FILE NUMBER

DEED

1. PLACE OF DEATH a. COUNTY <u>Sh. Louis</u>		2. USUAL RESIDENCE (Where deceased lived if institution: Residence before admission) a. STATE <u>Mo</u> b. COUNTY <u>Sh. Louis</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Lemay</u>		Length of stay in 1b <u>YRS.</u>	c. CITY OR TOWN <u>Lemay</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>146 N. 68th</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <u>146 N. 68th</u> Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>

3. NAME OF DECEASED (Type or print) First <u>JOSIE</u> Middle <u>ANN</u> Last <u>MOORE</u>			4. DATE OF DEATH Month <u>Aug.</u> Day <u>25</u> Year <u>1959</u>		
5. SEX <u>Female</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>8/9/1894</u>	9. AGE (last birthday) <u>65</u>	IF UNDER 1 YEAR IF UNDER 24 HR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>House Wife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Hardy Ark</u>	11. BIRTHPLACE (City and state or country) <u>USA</u>	12. CITIZEN OF WHAT COUNTRY <u>USA</u>	
13a. FATHER'S NAME <u>L.B. Thomas</u>		13b. MOTHER'S MAIDEN NAME <u>M. Guenter</u>		14. NAME OF HUSBAND OR WIFE <u>T.R. Thomas</u>	
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. <u>---</u>	17. INFORMANT <u>T.R. Thomas</u> Address <u>146 N. 68th</u>		

DOCUMENT

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>Acute dilation of heart</u>		INTERVAL BETWEEN ONSET AND DEATH <u>1/2 hr.</u> <u>several days.</u>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) <u>Chronic Cardiac vascular disease</u>	
	DUE TO (c)	

MEDICAL CERTIFICATION

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>Chronic arthritis - spinal (old) hemiplegia</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.)	
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 8-1-59 to 8-25-59 and last saw her alive on 8/25/59
Death occurred at 5:00 p.m. on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE <u>William D. Creech M.D.</u> (Degree or title)	22b. ADDRESS <u>702 Lemay Ferry Rd</u>	22c. DATE SIGNED <u>8-25-59</u>
--	--	---------------------------------

23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>	23b. DATE <u>Aug 26/59</u>	23c. NAME OF CEMETERY OR CREMATORY <u>LOCAL</u>	23d. LOCATION (City, town, or county) (State) <u>Wht View Ark.</u>
---	----------------------------	---	---

24. FUNERAL DIRECTOR <u>JOS E. [unclear]</u>	ADDRESS	25. DATE RECD. BY LOCAL REG. <u>8-26-59</u>	26. REGISTRAR'S SIGNATURE <u>John C. Murphy M.D.</u>
---	---------	---	---

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

Clarence Johnson

Licensed Embalmer No. 3093

P. O. Address 7128 Me

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.