

# JRI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

59-031303

FILED VS AUG 18 1959 360

Registration District No. \_\_\_\_\_ Primary Registration District No. 6225 Registrar's No. 130 STATE FILE NUMBER

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1. PLACE OF DEATH a. COUNTY <b>VERMONT</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MISSOURI</b> b. COUNTY <b>GREENE</b>				
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>WASHINGTON TOWNSHIP</b>		Length of stay in 1b <b>3 MONTHS, 5 DAYS</b>		c. CITY OR TOWN <b>SPRINGFIELD, MO GREENWOOD</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>STATE HOSPITAL #3, NEVADA, MO</b>			Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>		d. STREET ADDRESS (If outside, give location) <b>1601 LOMBARD</b>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <b>MARY JOSEPHINE VARLEY</b>				4. DATE OF DEATH Month Day Year <b>AUGUST 3 1959</b>				
5. SEX <b>F</b>	6. COLOR OR RACE <b>W</b>	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>		8. DATE OF BIRTH <b>MARCH-10-1899</b>	9. AGE (last birthday) <b>60</b>	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HR	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOUSEWIFE NURSE</b>			10b. KIND OF BUSINESS OR INDUSTRY <b>NONE</b>		11. BIRTHPLACE (City and state or country) <b>CHANDLERVILLE ILLINOIS</b>		12. CITIZEN OF WHAT COUNTRY <b>U.S.A</b>	
13a. FATHER'S NAME <b>COURTNEY ARIAS</b>			13b. MOTHER'S MAIDEN NAME <b>GRACE EVA MC MILLAM</b>			14. NAME OF HUSBAND OR WIFE <b>OTTO L. VARLEY</b>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>NO</b>			16. SOCIAL SECURITY NO. <b>- - -</b>		17. INFORMANT <b>HOSP. RECORDS</b>			Address <b>STATE HOSPITAL #3 NEVADA MO</b>
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>BRONCHOPNEUMONIA</b>							INTERVAL BETWEEN ONSET AND DEATH <b>3 DAYS</b>	
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) <b>ALZHEIMERS DISEASE</b>							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 Month, Day, Year 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 <b>4-28-1958</b> to <b>9-3-1959</b> and last saw her <sup>her</sup> alive on <b>8-3-1959</b> Death occurred at <b>10:15 P.M.</b> m on the date stated above, and to the best of my knowledge, from the causes stated.								
22a. SIGNATURE <b>W. C. Bradley M.D.</b> (Degree or title)				22b. ADDRESS <b>State Hospital #3, Nevada, Mo</b>		22c. DATE SIGNED <b>8-3-59</b> (State)		
23a. BURIAL, CREMATION REMOVAL (Specify) <b>Burial</b>	23b. DATE <b>1959</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Eldon Cemetery</b>		23d. LOCATION (City, town, or county) <b>Eldon, Missouri</b>				
24. FUNERAL DIRECTOR <b>Ferry Funeral Home Nevada, Missouri</b>				25. DATE RECD. BY LOCAL REG. <b>8-10-1959</b>		26. REGISTRAR'S SIGNATURE <b>Arma E. Jerry</b>		

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

KS JUN 10 1960

**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 L. Hughes Ferry

Licensed Embalmer No. 4960

P. O. Address Nevada

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.