

R.I. DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

FILED VS SEP 23 1959 *7*

59-031648

Registration District No. _____ Primary Registration District No. *3008* Registrar's No. *243*

STATE FILE NUMBER

1. PLACE OF DEATH a. COUNTY Callaway		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY Howard	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Fulton		Length of stay in 1b 16 days	c. CITY OR TOWN Fayette Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION State Hospital No. 1		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) 307 Lucky Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>

3. NAME OF DECEASED (Type or print) First MYRTLE Middle S. E. Last DYSON			4. DATE OF DEATH Month September Day 14 Year 1959			
5. SEX Female	6. COLOR OR RACE White	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH 8-20-1887	9. AGE (last birthday) 72	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) Missionary wife		10b. KIND OF BUSINESS OR INDUSTRY Same		11. BIRTHPLACE (City and state or country) Kansas		12. CITIZEN OF WHAT COUNTRY U. S. A.
13a. FATHER'S NAME F. B. Sheldon		13b. MOTHER'S MAIDEN NAME Elizabeth Heflin		14. NAME OF HUSBAND OR WIFE J. W. Dyson		

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. 091-26-3613 B Unknown	17. INFORMANT State Hospital No. 1, Fulton, Mo.
---	---	---

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial Failure		INTERVAL BETWEEN ONSET AND DEATH
DUE TO (b) Multiple pulmonary emboli		
DUE TO (c) Arteriosclerotic Heart Disease		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) Marked Cerebral Arteriosclerosis with old CVA		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 checked="" type="checkbox"/> NO <input 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 type="checkbox"/>	20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	20f. CITY, TOWN, OR LOCATION St. Hosp.	COUNTY _____ STATE _____
21. attended the deceased from 8-29-1959 to 9-14-59 Death occurred at 4:00 a.m. on the date stated above, and to the best of my knowledge, from the causes stated.			

22a. SIGNATURE <i>[Signature]</i>	(Degree or title) State Hospital No. 1 Fulton, Missouri	22c. DATE SIGNED 9-14-59
--------------------------------------	---	------------------------------------

23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE Sept-18-1959	23c. NAME OF CEMETERY OR CREMATOR Mt. Memorial Cem	23d. LOCATION (City, town, or county) (State) Kansas City, Mo
24. FUNERAL DIRECTOR Raymond A. Carr	ADDRESS Fayette, Mo	25. DATE RECD. BY LOCAL REG. Sept-14-1959	26. REGISTRAR'S SIGNATURE Margaret Lawrence

(Licensed Embalmer's Statement on Reverse Side)

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 William E. Treph

Licensed Embalmer No. 4876

P. O. Address Hayette

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.