

IRI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

59-031718

FILED VS SEP 28 1959

Registration District No. 55 Primary Registration District No. 3011 Registrar's No. 67

STATE FILE NUMBER

INDEXED

1. PLACE OF DEATH a. COUNTY <u>Carroll</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Carroll</u>					
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Carrollton</u>		Length of stay in 1b <u>Two Weeks</u>		c. CITY OR TOWN <u>Boyard</u>		Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>			
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>Bales Hospital</u>			Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location) <u>Heslie Township</u>		Reside on Farm Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First <u>Phillip</u> Middle <u>Edward</u> Last <u>Dorney</u>				4. DATE OF DEATH Month <u>September</u> Day <u>21</u> Year <u>1959</u>					
5. SEX <u>Male</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>1-3-1890</u>		9. AGE (last birthday) <u>69</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>Farmer</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>Farming</u>		11. BIRTHPLACE (City and state or country) <u>Carroll</u>		12. CITIZEN OF WHAT COUNTRY <u>USA</u>		
13a. FATHER'S NAME <u>Joseph Dorney</u>			13b. MOTHER'S MAIDEN NAME <u>Isabell Schultz</u>			14. NAME OF HUSBAND OR WIFE <u>Bessie Hull Dorney</u>			
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>490-42-272</u>		17. INFORMANT <u>Mr. Bessie Hull Dorney, Boyard, Mo.</u> 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) <u>Pemphigous Ulcers</u> DUE TO (b) _____ DUE TO (c) _____ Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.								INTERVAL BETWEEN ONSET AND DEATH <u>6 MO.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>Pl had bad tooth for many years in string.</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 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		COUNTY STATE	
21. I attended the deceased from <u>Sept 10 59</u> to <u>Sept 21</u> and last saw him alive on <u>Sept 21 1959</u> Death occurred at <u>11:30 PM</u> on the date stated above, and to the best of my knowledge, from the causes stated.									
22a. SIGNATURE <u>Cyrus Beard</u> (Degree or title)				22b. ADDRESS <u>Carrollton</u>				22c. DATE SIGNED <u>9-23-59</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE <u>Sept 23, 1959</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Smith Cemetery</u>		23d. LOCATION (City, town, or county) (State) <u>Boyard, Missouri</u>			
24. FUNERAL DIRECTOR <u>Dieterman Funeral Home, Boyard, Mo.</u>				25. DATE RECD. BY LOCAL REG. <u>9-23-59</u>		26. REGISTRAR'S SIGNATURE <u>Amberlynn Calvert</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 Samuel M Rice, Student Embalmer No. 577

working under my personal supervision.

Student Samuel M Rice
Signature of Student Embalmer

Signed

R. M. Marshall, Jr

Licensed Embalmer No. 4469

P. O. Address Carrollton

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.