

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

FILED VS SEP 21 1959 *71*

59-031769

Registration District No. _____ Primary Registration District No. *3012* Registrar's No. *77*

STATE FILE NUMBER

1. PLACE OF DEATH a. COUNTY Clay			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY Clay				
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Excelsior Springs		Length of stay in 1b		c. CITY OR TOWN Excelsior Springs		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Sharps Nursing Home			Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location)		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Robert Middle D Last Ewing			4. DATE OF DEATH Month Aug Day 1 Year 1959				
5. SEX Male	6. COLOR OR RACE White	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input checked="" type="checkbox"/>		8. DATE OF BIRTH July 28, 1880	9. AGE (last birthday) 79	IF UNDER 1 YEAR Months _____ Days _____ Hours _____ Min. _____	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Mail Carrier (retired)		10b. KIND OF BUSINESS OR INDUSTRY U.S. Postoffice		11. BIRTHPLACE (City and state or country) Liberty, Missouri		12. CITIZEN OF WHAT COUNTRY U.S.A.	
13a. FATHER'S NAME Chatman Ewing			13b. MOTHER'S MAIDEN NAME Anna Ford		14. NAME OF HUSBAND OR WIFE unknown		
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. unknown		17. INFORMANT Mrs. E. J. McKee - St. Joseph, Mo.		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) Cerebral Hemorrhage						INTERVAL BETWEEN ONSET AND DEATH sev. wks	
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) hypertension						sev. yrs	
DUE TO (c) arteriosclerosis						years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) senility					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 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 July 24, 1959 to Aug. 1, 1959 and last saw ^{him} alive on Aug. 1, 1959 Death occurred at 10:30 p.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)			22b. ADDRESS M. D. Excelsior Springs, Mo.		22c. DATE SIGNED 8/29/59		
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE 8-3-59	23c. NAME OF CEMETERY OR CREMATORY Crown Hill		23d. LOCATION (City, town, or county) (State) Excelsior Springs Mo.			
24. FUNERAL DIRECTOR Pritchard Funeral Home, Inc. Excelsior Springs, Missouri			25. DATE RECD. BY LOCAL REG. 8/21/59	26. REGISTRAR'S SIGNATURE <i>[Signature]</i>			

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 Ralph E. Van Linder

Licensed Embalmer No. 4009

P. O. Address Galena Springs, Mo.

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.