

# RI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

59-031863

FILED VS OCT 2 1959 93

59-74

STATE FILE NUMBER

IDED

Registration District No. \_\_\_\_\_ Primary Registration District No. \_\_\_\_\_ Registrar's No. \_\_\_\_\_

1. PLACE OF DEATH a. COUNTY <u>Dade</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Mo</u> b. COUNTY <u>Dade</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Lockwood Mo</u>		Length of stay in lb <u>11da</u>	c. CITY OR TOWN <u>Lockwood Mo</u> <input type="checkbox"/> 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>Memorial Hospital</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <u>1mi North</u> <input type="checkbox"/> Reside on Farm Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>

3. NAME OF DECEASED (Type or print) First <u>Matilda</u> Middle <u>Cathrine</u> Last <u>Pearson</u>			4. DATE OF DEATH Month <u>Sept</u> Day <u>15</u> Year <u>1959</u>	
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5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. Married <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <u>Nov 12 1883</u>	9. AGE (last birthday) <u>75</u>	IF UNDER 1 YEAR Months <u>10</u> Days <u>3</u> Hours <u>0</u> Min. <u>0</u>	IF UNDER 24 HR
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>House Work</u>	10b. KIND OF BUSINESS OR INDUSTRY <u>Farming</u>	11. BIRTHPLACE (City and state or country) <u>Dade Co Mo</u>	12. CITIZEN OF WHAT COUNTRY <u>USA</u>
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13a. FATHER'S NAME <u>Fred Pearson</u>	13b. MOTHER'S MAIDEN NAME <u>Virginia Lack</u>	14. NAME OF HUSBAND OR WIFE _____
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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>none</u>	17. INFORMANT <u>Carrie Gillman Lockwood Mo.</u>	Address _____
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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>Congestive Heart failure</u>		INTERVAL BETWEEN ONSET AND DEATH <u>2 days</u>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) <u>generalized debility</u>	<u>2 weeks</u>
	DUE TO (c) <u>Fractured Right hip</u>	<u>2 weeks</u>

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) _____	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
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19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20a. ACCIDENT <input checked="" 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.) <u>Pt fell while at home</u>
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20c. TIME OF INJURY Hour - Month, Day, Year a.m. <u>9-4-59</u> p.m.
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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.) <u>Home</u>	20f. CITY, TOWN, OR LOCATION <u>Lockwood, Dade Mo.</u>	COUNTY <u>Dade</u> STATE <u>Mo.</u>
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21. I attended the deceased from <u>4-4-59</u> to <u>9-15-59</u> and last saw <sup>her</sup> him alive on <u>9-14-59</u>	Death occurred at <u>5:32 A</u> on the date stated above, and to the best of my knowledge, from the causes stated.
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22a. SIGNATURE (Degree or title) <u>Emeru Taylor M.D.</u>	22b. ADDRESS <u>Lockwood, Mo</u>	22c. DATE SIGNED <u>9/16/59</u>
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23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE <u>Sept 17 1959</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Lockwood</u>	23d. LOCATION (City, town, or county) <u>Lockwood Mo.</u>
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24. FUNERAL DIRECTOR <u>Allison Funeral Home Greenfield Mo.</u>	25. DATE RECD. BY LOCAL REG. <u>9/19/59</u>	26. REGISTRARS SIGNATURE <u>J. C. Canada</u>
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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 W. R. Allison

Licensed Embalmer No. 4404

P. O. Address Greenville

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.