

# RI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

# 59-032881

FILED VS SEP 21 1959 164

Primary Registration District No. 205601

Registrar's No. 119

STATE FILE NUMBER

DED

1. PLACE OF DEATH a. COUNTY <b>JOHNSON</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MISSOURI</b> b. COUNTY <b>JOHNSON</b>				
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>WARRENSBURG TWO</b>		Length of stay in lb <b>2 YRS</b>		c. CITY OR TOWN <b>WARRENSBURG</b>		Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>		
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>SUNRISE NURSING HOME</b>			Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>		d. STREET ADDRESS (If outside, give location) <b>SUNRISE NURSING HOME</b>		Reside on Farm Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>LUCINDA</b> Middle <b>JANE</b> Last <b>IRVINE</b>				4. DATE OF DEATH Month <b>SEPT</b> Day <b>14</b> Year <b>1959</b>				
5. SEX <b>F</b>	6. COLOR OR RACE <b>W</b>	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>		8. DATE OF BIRTH <b>4/9/65</b>	9. AGE (last birthday) <b>94</b>	IF UNDER 1 YEAR Months <b>5</b> Days <b>5</b>	IF UNDER 24 HR Hours <b></b> Min. <b></b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOUSEWORK</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>OWN HOME</b>		11. BIRTHPLACE (City and state or country) <b>TOPEKA KANSAS</b>		12. CITIZEN OF WHAT COUNTRY <b>U.S.A.</b>		
13a. FATHER'S NAME <b>MORGAN</b>		13b. MOTHER'S MAIDEN NAME <b>UNKNOWN</b>		14. NAME OF HUSBAND OR WIFE <b>CHARLES IRVINE</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>NONE</b>		17. INFORMANT <b>PEARL IRVINE CENTERVIEW, MO</b> 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) <b>Carcinoma of colon</b>							INTERVAL BETWEEN ONSET AND DEATH <b>6 mos.</b>	
DUE TO (b) <b>arteriosclerotic cardiovascular disease</b>							years	
DUE TO (c)								
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	
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 <b></b> Month, Day, Year <b></b>								
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>8-8-59</b> to <b>9-14-59</b> and last saw her alive on <b>9-14-59</b> Death occurred at <b>3:25 PM 9-14-59</b> m on the date stated above, and to the best of my knowledge, from the causes stated.								
22a. SIGNATURE (Degree or title) <b>Raymond H. Orange, M.D.</b>				22b. ADDRESS <b>Warrensburg, Mo.</b>		22c. DATE SIGNED <b>9-16-59</b>		
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>	23b. DATE <b>SEPT 16 1959</b>	23c. NAME OF CEMETERY OR CREMATORY <b>HOLDEN CEMETERY</b>		23d. LOCATION (City, town, or county) (State) <b>HOLDEN MISSOURI</b>				
24. FUNERAL DIRECTOR <b>CANADAY &amp; ROPP HOLDEN MO</b>				25. DATE RECD. BY LOCAL REG. <b>Sept. 19, 1959</b>		26. REGISTRAR'S SIGNATURE <b>Lavanack Cutchfield</b>		

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. L. Cusack*

Licensed Embalmer No. 3434

P. O. Address *Holden, N.*

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.