

FRI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

59-032987

FILED VS OCT 5 1959 385

Registration District No. 385 Primary Registration District No. 3039 Registrar's No. 75

STATE FILE NUMBER

INDEXED

1. PLACE OF DEATH a. COUNTY <u>Linn</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Mo</u> b. COUNTY <u>Linn</u>					
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Marceline</u>		Length of stay in 1b <u>39 yrs.</u>		c. CITY OR TOWN <u>Marceline</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>			
c. FULL NAME OF (IF NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>Chestnut & Crocker</u>			Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location) <u>Chestnut & Crocker</u>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First <u>Ella</u> Middle <u>Herndon</u> Last <u>Herndon</u>				4. DATE OF DEATH Month <u>9</u> Day <u>21</u> Year <u>59</u>					
5. SEX <u>F</u>	6. COLOR OR RACE <u>C</u>	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>		8. DATE OF BIRTH <u>5-16-1871</u>	9. AGE (last birthday) <u>88</u>	IF UNDER 1 YEAR Months <u>4</u> Days <u>3</u>	IF UNDER 24 HR Hours <u></u> Min. <u></u>		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (City and state or country) <u>Darton, Mo.</u>		12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>		
13a. FATHER'S NAME <u>Henry Trent</u>			13b. MOTHER'S MAIDEN NAME <u>Fannie Price</u>			14. NAME OF HUSBAND OR WIFE <u>Robert (dec)</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>none</u>		17. INFORMANT <u>Cornie Herndon Marceline 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>Acute myocardial decompensation</u>							INTERVAL BETWEEN ONSET AND DEATH <u>3 days</u>		
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <u>Arteriosclerosis</u>							<u>indefinite</u>		
DUE TO (c) <u>Senility and inanition</u>							<u>indef.</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 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 <u></u> Month, Day, Year <u></u>									
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>July 2, 1955</u> to <u>9-21-1959</u> and last saw her <u>alive</u> on <u>9-21-59</u> Death occurred at <u>7:15</u> <u>A.</u> m on the date stated above, and to the best of my knowledge, from the causes stated.									
22a. SIGNATURE <u>John Otis Carr D.O.</u> (Degree or title)				22b. ADDRESS <u>124 W. Ritchie St. Marceline</u>				22c. DATE SIGNED <u>9-22-1959</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE <u>9-24-59</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Mt. Olivet</u>		23d. LOCATION (City, town, or county) <u>Marceline, Mo</u>		(State)		
24. FUNERAL DIRECTOR <u>James M Laughlin</u> ADDRESS <u>Marceline Mo</u>				25. DATE RECD. BY LOCAL REG. <u>9-22-59</u>		26. REGISTRAR'S SIGNATURE <u>Bessie Owens</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 _____, Student Embalmer No. _____
working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed James B. McCallum

Licensed Embalmer No. 4230

P. O. Address Brookfield

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.