

URI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

59-033325

FILED VS SEP 16 1959

278

Primary Registration District No. 3054

Registrar's No. 109

STATE FILE NUMBER

ENDED

1. PLACE OF DEATH a. COUNTY <b>PIKE</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MO</b> b. COUNTY <b>PIKE</b>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>LOUISIANA.</b>	Length of stay in 1b <b>30 YRS.</b>	c. CITY OR TOWN <b>LOUISIANA.</b>	Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>118 N 3rd St.</b>	Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <b>118 N 3rd St.</b>	Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print) First <b>MARY</b> Middle <b>ANN</b> Last <b>HALEY</b>			4. DATE OF DEATH Month <b>SEPT</b> Day <b>6</b> Year <b>1959.</b>	
--	--	--	--	--

5. SEX <b>FEMALE</b>	6. COLOR OR RACE <b>WHITE</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>11-26-1922. 76</b>	9. AGE (last birthday) <b>76</b>	IF UNDER 1 YEAR Months <input type="checkbox"/> Days <input type="checkbox"/> Hours <input type="checkbox"/> Min. <input type="checkbox"/>	IF UNDER 24 HR. Hours <input type="checkbox"/> Min. <input type="checkbox"/>
-------------------------	----------------------------------	---	---	-------------------------------------	---	---

10a. USUAL OCCUPATION (Give kind of work done during last 12 months of working life, even if retired) <b>HOUSEWIFE</b>	10b. KIND OF BUSINESS OR INDUSTRY <b>HOME</b>	11. BIRTHPLACE (City and state or country) <b>TAYLORVILLE ILL</b>	12. CITIZEN OF WHAT COUNTRY <b>USA.</b>
---	--	--	--

13a. FATHER'S NAME <b>JOHN M. STERRETT</b>	13b. MOTHER'S MAIDEN NAME <b>LUCY WALTERS</b>	14. NAME OF HUSBAND OR WIFE <b>F.C. HALEY Jr.</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>WAYNE D. HUNTER - DAVE AIRPORT TOWN</b>
---	--	---

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>Coronary occlusion</b>		INTERVAL BETWEEN ONSET AND DEATH <b>none</b>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) <b>arterio sclerosis.</b>	<b>several years</b>
	DUE TO (c)	<b>prolonged</b>

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 <input type="checkbox"/> a.m. <input type="checkbox"/> 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 <b>LOUISIANA</b>	COUNTY <b>MO</b>	STATE
--	--	--	---------------------	-------

21. I attended the deceased from **SEPT. 5, 1959** to **SEPT 6, 1959** and last saw her alive on **Sept 5, 1959**  
Death occurred at **8:30 A.M.** m on the date stated above, and to the best of my knowledge from the causes stated.

22a. SIGNATURE <b>G. L. B. B...</b> (Degree or title)	22b. ADDRESS <b>LOUISIANA MO</b>	22c. DATE SIGNED <b>9-8-59</b>
--	-------------------------------------	-----------------------------------

23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>	23b. DATE <b>SEPT 9, 1959</b>	23c. NAME OF CEMETERY OR CREMATORY <b>RIVERVIEW</b>	23d. LOCATION (City, town, or county) <b>LOUISIANA</b>	(State) <b>MO</b>
--	----------------------------------	--	---	----------------------

24. FUNERAL DIRECTOR <b>COLLIER FUNERAL SERVICE</b>	ADDRESS <b>LOUISIANA MO</b>	25. DATE RECD. BY LOCAL REG. <b>Sept 8 1959</b>	26. REGISTRAR'S SIGNATURE <b>Blanche Collier</b>
--	--------------------------------	--	---

(Licensed Embalmer's Statement on Reverse Side)

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 me  
or by \_\_\_\_\_, Student Embalmer No. \_\_\_\_\_  
working under my personal supervision.

Student \_\_\_\_\_  
Signature of Student Embalmer

Signed Geo M. Callier

Licensed Embalmer No. 3839

P. O. Address Louisiana

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.