

URI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

59-034942

FILED VS OCT 13 1959 53

STATE FILE NUMBER

Registration District No. 53 Primary Registration District No. 6196 Registrar's No. 20

1. PLACE OF DEATH a. COUNTY <u>Texas</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Mo</u> b. COUNTY <u>Texas</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Licking</u>		Length of stay in 1b <u>10 yrs</u>	c. CITY OR TOWN <u>Licking</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		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <u>-</u> Residence Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print) First Middle Last <u>Cleo Charles Comer</u>			4. DATE OF DEATH Month Day Year <u>Oct 5 1959</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <u>2-14-1904</u>	9. AGE (last birthday) <u>55</u>
10. USUAL PLACE OF BIRTH (If outside, give name of town, city, county, and state, even if changed)		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and state or country) <u>Quaintance, Ill USA</u>	
12. CITIZEN OF WHAT COUNTRY		12. CITIZEN OF WHAT COUNTRY <u>USA</u>		

13a. FATHER'S NAME <u>Jacob Comer</u>		13b. MOTHER'S MAIDEN NAME <u>Cora Howell</u>		13c. NAME OF HUSBAND OR WIFE <u>Rosa Comer</u>	
14. 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>491-12-2727</u>		17. INFORMANT <u>Rosa Comer Licking Mo</u> Address	

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY:		INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a) <u>Cardiac + pulmonary aurt.</u>		<u>10 Minutes</u>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) <u>Coronary occlusion</u>	
	DUE TO (c) <u>Coronary thrombosis</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 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 <u>Death on arrival</u> to <u>her</u> and last saw him <u>alive on</u> Death occurred at <u>3:30 P.M.</u> on the date stated above, and to the best of my knowledge, from the causes stated.			

22a. SIGNATURE (Degree or title) <u>B. J. Myers DO</u>		22b. ADDRESS <u>Licking, Mo.</u>		22c. DATE SIGNED <u>10-7-59</u>
23a. BURIAL, CREMATION, OR REMOVAL (Specify)	23b. DATE <u>10-8-59</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Cavaness</u>	23d. LOCATION (City, town, or county) (State) <u>Lynchburg, Va. Mo</u>	
24. FUNERAL DIRECTOR ADDRESS <u>Smith Ferguson Licking Mo</u>		25. DATE RECD. BY LOCAL REG. <u>Oct. 8, 1959</u>	26. REGISTRAR'S SIGNATURE <u>Elnora B. Hesse</u>	

(Licensed Embalmer's Statement on Reverse Side)

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

OCT 20 1959

MS OCT 23 1959

DEC 29 1959

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 Robert E. Fuguso

Licensed Embalmer No. 3945

P. O. Address Richmond

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.