

FILED VS OCT 6 1959 STANDARD CERTIFICATE OF DEATH

STATE FILE NUMBER

Registration District No. 374 Primary Registration District No. 1 Registrar's No.

V. S. 300
Rev. 1-57

130

securing the medical certification in the specific manner required by 193.140 MoRS 1949.
Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed.
All diseases in Part I must be causally related.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

1. PLACE OF DEATH a. COUNTY <u>Worth</u>			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Iowa</u> b. COUNTY <u>Ringgold</u>		
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Union Twp</u>		Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	c. CITY OR TOWN <u>Mount Airy (Pike Twp)</u>		Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION		Length of stay in 1b <u>3 yrs</u>	d. STREET ADDRESS (If outside, give location)		Reside on Farm Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <u>Mary</u> Middle <u>B</u> Last <u>Brown</u>			4. DATE OF DEATH Month <u>Sept</u> Day <u>19</u> Year <u>1959</u>		
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</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>Nov. 5-1878</u>		9. AGE (In years last birthday) <u>81</u> IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>House Keeper</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>SELF</u>	11. BIRTHPLACE (City and state or country) <u>Ohio</u>		12. CITIZEN OF WHAT COUNTRY? <u>U S C.</u>
13a. FATHER'S NAME <u>James Ross</u>		13b. MOTHER'S MAIDEN NAME <u>Lucy Borden</u>		14. NAME OF HUSBAND OR WIFE <u>Andrew Brown</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service)		16. SOCIAL SECURITY NO.	17. INFORMANT <u>James P. Ross</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>Cerebral Embolism due to</u> <u>Dementia Gravitata</u> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. } DUE TO (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)					INTERVAL BETWEEN ONSET AND DEATH <u>10 minutes</u> <u>5 days</u>
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 <input type="checkbox"/> NOT WHILE WORK <input type="checkbox"/> 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>1957</u> , to <u>Sept 19, 59</u> and last saw ^{her} / _{him} alive on <u>Sept 16, 1959</u> . Death occurred at <u>6 PM</u> on the date stated above; and to the best of my knowledge, from the causes stated.					
22a. SIGNATURE (Degree or title) <u>Frank B. Matzson MD</u>			22b. ADDRESS <u>Grant City Mo</u>		22c. DATE SIGNED <u>9-22-59</u>
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE <u>9-22-59</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Rose Hill</u>		23d. LOCATION (City, town, or county) (State) <u>Mount Airy 1020 cc.</u>
24. FUNERAL DIRECTOR <u>H. P. Rhoads</u>		ADDRESS <u>Mount Airy Mo</u>		25. DATE RECD. BY LOCAL REG. <u>Sept 30 1959</u>	26. REGISTRAR'S SIGNATURE <u>Beverly Kibbe</u>

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~~ *C. O. Rhoads*, Student Embalmer No. working under my personal supervision.

Student
Signature of Student Embalmer

Signed *C. O. Rhoads*

Licensed Embalmer No. *4759*

P. O. Address *Mount Airy, N.C.*

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.