

URI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

59-035023

FILED VS SEP 25 1959

STATE FILE NUMBER

Registration District No. 325 Primary Registration District No. 6279 Registrar's No. 32

ENDED

1. PLACE OF DEATH a. COUNTY Wright				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Mo. b. COUNTY Wright				
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Gasconade		Length of stay in 1b 10 years		c. CITY OR TOWN Hartsville, Mo.		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION 8 mi. West of Hartsville			Inside Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location) 8 mi. West of Hartsville		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Edith Middle Ann Last Nichols				4. DATE OF DEATH Month July Day 9 Year 1959				
5. SEX Female	6. COLOR OR RACE White	7. Married <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>		8. DATE OF BIRTH 12/19/1887	9. AGE (last birthday) 71	IF UNDER 1 YEAR Months 6 Days 20	IF UNDER 24 HR Hours 0 Min. 0	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (City and state or country) Webster County, Mo. U.S.A.		12. CITIZEN OF WHAT COUNTRY U.S.A.	
13a. FATHER'S NAME Fate Nichols			13b. MOTHER'S MAIDEN NAME Sarah Angelina Newton		14. NAME OF HUSBAND OR WIFE Florence Cantrell Marshfield			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No.			16. SOCIAL SECURITY NO. None		17. INFORMANT Florence Cantrell Marshfield			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)			Cardiac Arrhythmia				acute	
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.			DUE TO (b)		Congestive Heart Failure			
			DUE TO (c)		Hypertensive Cardiovascular Disease			
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		COUNTY		STATE
21. I attended the deceased from 12 Feb 1959 to 9 July 59 and last saw her ^{her} alive on 23 June 59 Death occurred at 4:40 Pm m on the date stated above, and to the best of my knowledge, from the causes stated.								
22a. SIGNATURE (Degree or title) J. M. Macdonnell MD				22b. ADDRESS Marshfield, Mo			22c. DATE SIGNED 25 Sept 59	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE 7/12/1959	23c. NAME OF CEMETERY OR CREMATORY Mt. Zion Cemetery		23d. LOCATION (City, town, or county) Wright County, Mo.				(State)
24. FUNERAL DIRECTOR John D. Simpson			ADDRESS Hartsville, Mo.		25. DATE RECD. BY LOCAL REG. Sept. 21, 1959		26. REGISTRAR'S SIGNATURE Bonnie J. Jones	

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 _____

Licensed Embalmer No. _____

P. O. Address _____

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.