

FRI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH
FILED VS NOV 2 1959

59-035039

STATE FILE NUMBER

Registration District No. 1 Primary Registration District No. 3000 Registrar's No. 322

1. PLACE OF DEATH		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)	
a. COUNTY <u>ADAIR</u>	a. STATE <u>Mo.</u>	b. COUNTY <u>Adair</u>	admission)
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>KIRKSVILLE</u>	Length of stay in 1b	c. CITY OR TOWN <u>Kirksville</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>C.N.N. #1</u>	Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <u>606-S-Franklin</u>	Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>

3. NAME OF DECEASED (Type or print)			4. DATE OF DEATH	
First <u>HATTIE</u>	Middle <u>M.</u>	Last <u>MASON</u>	Month <u>10</u>	Day <u>31</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>4-4-1863</u>	9. AGE (last birthday) <u>96</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housekeeper</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Domestic</u>	11. BIRTHPLACE (City and state or country) <u>Milan, Mo.</u>	12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>
13a. FATHER'S NAME <u>Oliver P. Phillips</u>		13b. MOTHER'S MAIDEN NAME <u>Mariah C. Witter</u>		14. NAME OF HUSBAND OR WIFE <u></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></u>		
		17. INFORMANT <u>Clyde E. Jones, Yucaipa, Calif</u>		

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)		INTERVAL BETWEEN ONSET AND DEATH <u>WEEKS</u> <u>MONTHS</u> <u>?</u>
PART I. DEATH WAS CAUSED BY:		
IMMEDIATE CAUSE (a) <u>CACHEXIA AND INANITION</u>	DUE TO (b) <u>CEREBRAL ENCEPHALOMALACIA</u>	
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (c) <u>CEREBRAL ARTERIOSCLEROSIS</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 checked="" type="checkbox"/> No <input type="checkbox"/> Unknown

19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" 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 Month, Day, Year a.m. p.m.		

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>SEPT 1, 1959</u> to <u>10/31/59</u> and last saw her alive on <u>10/20/59</u> Death occurred at <u>11:10</u> A.m. on the date stated above, and to the best of my knowledge, from the causes stated.				

22a. SIGNATURE (Degree or title) <u>William F. Bergin D.O.</u>	22b. ADDRESS <u>KIRKSVILLE.</u>	22c. DATE SIGNED <u>10/31/59</u>
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE <u>10-23-59</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Greencastle Cem</u>
23d. LOCATION (City, town, or county) <u>Greencastle, Mo.</u>		
24. FUNERAL DIRECTOR <u>Harris + Harris, Kirksville, Mo.</u>	25. DATE RECD. BY LOCAL REG. <u>10-30-1959</u>	26. REGISTRAR'S SIGNATURE <u>Doris W. Patliff</u>

(Licensed Embalmer's Statement on Reverse Side)

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

WILLIAM F. BERGEN, D.O.

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 Robert B. Davis

Licensed Embalmer No. 4219

P. O. Address Kirkville,

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.