URI DIVISION OF HEALTH – STANDARD CERTIFICATE OF DEATH

59–035104

STATE FILE NUMBER

FILED VS OCT 23 1959

AMENDED

Registration District No. 13 Primary Registration District No. 3003 Registrar's No. 132

1. PLACE OF DEATH
a. COUNTY: BARRY
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN: MONETT
Length of stay in 1b:
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION: ST. VINCENT HOSPITAL
Inside Limits: Yes ☒ No ☐

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: MISSOURI
b. COUNTY: BARRY
c. CITY OR TOWN: CASSVILLE
Inside Limits: Yes ☐ No ☒
d. STREET ADDRESS (If outside, give location): R.F.D. (Flat Creek Twp)
Reside on Farm: Yes ☒ No ☐

3. NAME OF DECEASED (Type or print): First: MELISSA Middle: CORDELIA Last: KELLIM
4. DATE OF DEATH: Month: Oct. Day: 9 Year: 1959
5. SEX: Female
6. COLOR OR RACE: White
7. Married ☒ Never Married ☐ Widowed ☐ Divorced ☐
8. DATE OF BIRTH: 6-16-90
9. AGE (last birthday): 69
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HR: Hours / Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife
10b. KIND OF BUSINESS OR INDUSTRY: Home
11. BIRTHPLACE (City and state or country): Walnut Grove, Minn.
12. CITIZEN OF WHAT COUNTRY: USA
13a. FATHER'S NAME: Delos Russell
13b. MOTHER'S MAIDEN NAME: Eva Nash
14. NAME OF HUSBAND OR WIFE: A.S. Kellim
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: A.S. Kellim, R.F.D Cassville, Mo.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Intestinal obstruction
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.
DUE TO (b): Ca of Colon Metastasis
DUE TO (c): to liver
INTERVAL BETWEEN ONSET AND DEATH:
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. ☐ Yes ☐ No ☐ Unknown
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐
20a. ACCIDENT ☐ SUICIDE ☐ HOMICIDE ☐
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 ☐ NOT WHILE AT WORK ☐
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 6-13-58, to 10-9-59 and last saw her alive on 10-9-59
Death occurred at 11:15 p.m. on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE: Charles Price M.D. (Degree or title)
22b. ADDRESS: Cassville, Mo.
22c. DATE SIGNED: 10-12-59

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE: 10-14-59
23c. NAME OF CEMETERY OR CREMATORY: Mineral Springs Cemetery
23d. LOCATION (City, town, or county) (State): Barry Co. Mo.
24. FUNERAL DIRECTOR: Doyle E. Williamson, ADDRESS: Cassville, Mo.
25. DATE RECD. BY LOCAL REG.: 10-19-59
26. REGISTRAR'S SIGNATURE: Mrs P.M. Cook

(Licensed Embalmer's Statement on Reverse Side)

DOCUMENT

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 Doyle E Williamson

Licensed Embalmer No. 4883

P. O. Address Cassville, Mo

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to compl 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.