

URI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

59-035493

FILED VS OCT 30 1959 62

Registration District No. _____ Primary Registration District No. 4709 Registrar's No. 30

STATE FILE NUMBER

UNDECEASED

1. PLACE OF DEATH a. COUNTY Cedar		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri COUNTY Cedar	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Stockton		Length of stay in 1b	c. CITY OR TOWN Stockton
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION 400 S. High St.		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) 400 S. High St.
			Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print) First Middle Last MYRTLE ANN WYNES			4. DATE OF DEATH Month Day Year Oct. 20, 1959		
--	--	--	---	--	--

5. SEX Female	6. COLOR OR RACE White	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH 8/20/78	9. AGE (last birthday) 81	IF UNDER 1 YEAR Months 2 Days 0 Hours 0 Min.	IF UNDER 24 HR
------------------	---------------------------	---	-----------------------------	------------------------------	---	----------------

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife	10b. KIND OF BUSINESS OR INDUSTRY Own Home	11. BIRTHPLACE (City and state or country) Stockton, Mo.	12. CITIZEN OF WHAT COUNTRY U.S.A.
--	---	---	---------------------------------------

13a. FATHER'S NAME J. L. Samsel	13b. MOTHER'S MAIDEN NAME Millie Luney	14. NAME OF HUSBAND OR WIFE
------------------------------------	---	-----------------------------

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 Arthur Wynes, Stockton, Mo.	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)	Cerebral Vascular Accident	hrs.
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) arteriosclerotic hypertension	days
	DUE TO (c)	

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 9.7.55 to 10.19.59 and last saw ^{her}him alive on 10.19.59
Death occurred at _____ m on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Doctor or title) Wm. B. Rucker M.D.	22b. ADDRESS Stockton Mo	22c. DATE SIGNED 10.23.59
---	-----------------------------	------------------------------

23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE 10/22/1959	23c. NAME OF CEMETERY OR CREMATORY Stockton City Cemetery	23d. LOCATION (City, town, or county) Stockton, Mo.	(State)
---	-------------------------	--	--	---------

24. FUNERAL DIRECTOR Cantlon Fun. Home, Stockton, Mo.	ADDRESS	25. DATE RECD. BY LOCAL REG. 10-24-59	26. REGISTRAR'S SIGNATURE General Garrison
--	---------	--	---

(Licensed Embalmer's Statement on Reverse Side)

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 me

or by _____, Student Embalmer No. _____

working under my personal supervision.

Student _____

Signature of Student Embalmer

Signed

John A. Cantlon

Licensed Embalmer No. 4387

P. O. Address Stockton, Mo.

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.