

MURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

59-035671

FILED VS NOV 6 1959

STATE FILE NUMBER

Registration District No. 098 Primary Registration District No. _____ Registrar's No. _____

MEMENDED

1. PLACE OF DEATH a. COUNTY <u>Davies</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Mo.</u> b. COUNTY <u>Harrison</u>				
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Gallatin, Mo.</u>		Length of stay in 1b <u>1 yr.</u>		c. CITY OR TOWN <u>Bethary (rural) Mo.</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 <u>Cox Rest Home</u>			Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>		d. STREET ADDRESS (If outside, give location)		Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Nellie</u> - Middle <u>Thompson</u> Last _____				4. DATE OF DEATH Month <u>Oct.</u> Day <u>18</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>1-25-1884</u>	9. AGE (last birthday) <u>75</u>	IF UNDER 1 YEAR Months <u>8</u> Days <u>23</u>	IF UNDER 24 HR Hours _____ Min. _____	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>housewife</u>			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (City and state or country) <u>Davies Co., Mo.</u>		12. CITIZEN OF WHAT COUNTRY <u>U.S. America</u>	
13a. FATHER'S NAME <u>James Birge</u>			13b. MOTHER'S MAIDEN NAME <u>Nancy Terry</u>			14. NAME OF HUSBAND OR WIFE <u>Thurman</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>none</u>		17. INFORMANT <u>Don Thompson</u> Address <u>Bethany, Missouri</u>				
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>Labor pneumonia</u>							INTERVAL BETWEEN ONSET AND DEATH <u>3 days</u>	
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <u>Cancer of breast & lungs</u>							<u>2 yrs</u>	
DUE TO (c) <u>Hemorrhage from lung</u>							<u>2 days</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>Secondary anemia, arterial sclerosis</u>						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.) <u>Was in Cancer Hospital in Columbia Mo. & could do nothing for her</u>						
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 <u>Sept 20</u> to <u>Oct 18</u> and last saw her alive on <u>Oct 18/59</u> Death occurred at <u>4 AM</u> on the date stated above, and to the best of my knowledge, from the causes stated.								
22a. SIGNATURE (Degree or title) <u>H. Bailey d.d.</u>				22b. ADDRESS <u>Gallatin Mo</u>		22c. DATE SIGNED <u>Oct 20 59</u>		
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>burial</u>	23b. DATE <u>10/20/59</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Masonic</u>		23d. LOCATION (City, town, or county) <u>Gilman City, Missouri</u>		(State) <u>59</u>		
24. FUNERAL DIRECTOR <u>M. Haas</u> ADDRESS <u>Bethany, Mo.</u>			25. DATE RECD. BY LOCAL REG. <u>28 Oct. 1959</u>		26. REGISTRAR'S SIGNATURE <u>Hugh M. Engelhart</u>			

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

W B Haas

Licensed Embalmer No. 3899

P. O. Address Bethany 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.