

FURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH
FILED VS NOV 9 1959

59-035728

STATE FILE NUMBER

Registration District No. 115-116 Primary Registration District No. 3030 Registrar's No. 241

UNRECORDED

1. PLACE OF DEATH a. COUNTY Franklin		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri COUNTY Franklin	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Washington, Mo.		Length of stay in 1b 2 Month	c. CITY OR TOWN St. Clair, 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 St Francis Hospital		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) none Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print) First MADA Middle L. Last KITCHELL			4. DATE OF DEATH Month Oct. Day 31, Year 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 Jan. 25, 1882	9. AGE (last birthday) 77	IF UNDER 1 YEAR Months 9 Days 6 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 General Work	11. BIRTHPLACE (City and state or country) Muncie, Ind.	12. CITIZEN OF WHAT COUNTRY U. S. A.
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13a. FATHER'S NAME Benjamin Boyd	13b. MOTHER'S MAIDEN NAME Julia Weier	14. NAME OF HUSBAND OR WIFE *****
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15. WAS DECEASED EVER IN U.S. ARMED SERVICES? (Yes, no, or unknown) (If yes, give war or dates of service) no	16. SOCIAL SECURITY NO. no	17. INFORMANT Address Sherwood W. Kitchell St. Clair, Mo.
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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) ACUTE LEFT VENT. FAILURE		2 1/2 hrs
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) ARTERIO-SCLEROTIC C.V. DISEASE LONG STANDING ESSENTIAL HYPERTENSION MYOCARDIAL DAMAGE	6 mo.
	DUE TO (c)	YEARS

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) SEVERAL PAROXYSMS ATTACKS OF FAILURE	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
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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.)
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20c. TIME OF INJURY Hour s.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
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21. I attended the deceased from 1955 to Death and last saw her him alive on 10-31-59

Death occurred at 11 p on the date stated above, and to the best of my knowledge, from the causes stated.		
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22a. SIGNATURE (Degree or title) John F. Pearl, m.d.	22b. ADDRESS St. Clair, Mo.	22c. DATE SIGNED 11-1-59
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23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE Nov. 3, 1959	23c. NAME OF CEMETERY OR CREMATORY Oak Grove Cemetery	23d. LOCATION (City, town, or county) (State) St. Louis, County, Missouri
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24. FUNERAL DIRECTOR ADDRESS Sherwood W. Kitchell St. Clair, Mo.	25. DATE RECD. BY LOCAL REG. 11/3/59	26. REGISTRAR'S SIGNATURE W. J. Williams
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(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
or by _____, Student Embalmer No. _____
working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed

Lester A. Whit

Licensed Embalmer No. *3254*

P. O. Address *Washington*

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.