

FURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

FILED VS NOV 12 1959

59-036777

STATE FILE NUMBER

Registration District No. 383 Primary Registration District No. 5655 Registrar's No. 122

RENDERED

1. PLACE OF DEATH a. COUNTY Lawrence				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY Polk			
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Mt. Vernon		Length of stay in lb 423 days		c. CITY OR TOWN Bolivar		Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Missouri State Sanatorium			Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	d. STREET ADDRESS (If outside, give location) Route 2		Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Earl Middle Edmond Last Angle			4. DATE OF DEATH Month Oct. Day 26, Year 1959				
5. SEX Male	6. COLOR OR RACE White	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input checked="" type="checkbox"/>		8. DATE OF BIRTH July 25, 1910	9. AGE (last birthday) 49	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HR Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Carpenter		10b. KIND OF BUSINESS OR INDUSTRY Carpentry		11. BIRTHPLACE (City and state or country) Halfway, Mo.		12. CITIZEN OF WHAT COUNTRY USA	
13a. FATHER'S NAME Phillip Alfred Angle			13b. MOTHER'S MAIDEN NAME Nora Alice Stanley			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. 523-05-9130		17. INFORMANT Address San. records, Mo. State San., Mt. Vernon, Mo.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Lymphosarcoma, retroperitoneal, abdomen causing chronic obliterative pericarditis; Chronic encephalomalacia, right cerebral hemisphere & pons of brain, post infarction; emaciation secondary to malignancy Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.						INTERVAL BETWEEN ONSET AND DEATH 1 yr. +	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) Chronic Pulmonary tuberculosis and tuberculous lymphadenitis; chronic obliterative pleuritis						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 checked="" 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 <input type="checkbox"/> a.m. <input type="checkbox"/> 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 8-29-58 , to 10-26-59 and last saw him alive on 10-26-59 Death occurred at 10:00 a.m. on the date stated above, and to the best of my knowledge, from the causes stated.							
22a. SIGNATURE (Degree or title) Edmond Angle			22b. ADDRESS Mt. Vernon, Mo.			22c. DATE SIGNED 10-26-59	
23a. BURIAL, CREMATION, OR REMOVAL (Specify) Removal		23b. DATE 10-26-59	23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City, town, or county) (State) Bolivar Mo		
24. FUNERAL DIRECTOR May L. Fournet		ADDRESS 11-3-59		25. DATE RECD. BY LOCAL REG. 11-3-59	26. REGISTRAR'S SIGNATURE Cecil Hendricks		

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 Max L. Fournet

Licensed Embalmer No. 41252

P. O. Address Wickham

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.