

**JURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH**

**59-037031**

**FILED VS OCT 26 1959**

STATE FILE NUMBER

Registration District No. 231 Primary Registration District No. 051 Registrar's No. 237

ENDED

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

3. NAME OF DECEASED (Type or print) First <b>ZACHARIAH</b> Middle <b>TAYLOR</b> Last <b>VANSICKLE</b>	4. DATE OF DEATH Month <b>Oct.</b> Day <b>14</b> Year <b>1959</b>
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5. SEX <b>m</b>	6. COLOR OR RACE <b>W</b>	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <b>10-13-70</b>	9. AGE (last birthday) <b>89</b>	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HR Hours Min.
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>insurance agent</b>	10b. KIND OF BUSINESS OR INDUSTRY <b>Insurance</b>	11. BIRTHPLACE (City and state or country) <b>Elmo, Mo.</b>	12. CITIZEN OF WHAT COUNTRY <b>USA</b>
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13a. FATHER'S NAME <b>A.J. Vansickle</b>	13b. MOTHER'S MAIDEN NAME <b>Elizabeth Roberts</b>	14. NAME OF HUSBAND OR WIFE <b>Eunice Vansickle, dec.</b>
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>no</b>	16. SOCIAL SECURITY NO. <b>no</b>	17. INFORMANT <b>Donald Lamar, Elmo, Mo.</b>	Address
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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: IMMEDIATE CAUSE (a) <b>Cerebro. vascular thrombosis</b> DUE TO (b) <b>Cerebral Arteriosclerosis</b> DUE TO (c) _____ Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	INTERVAL BETWEEN ONSET AND DEATH <b>Dec 1958</b> <b>36 hours.</b>
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PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <b>Prostatic Hypertrophy &amp; retention.</b>	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
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19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	20a. ACCIDENT <input type="checkbox"/> SUICIDE <input checked="" 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 _____ a.m. _____ p.m. Month, Day, Year _____
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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 <b>Elmo</b>	COUNTY <b>Mo.</b>	STATE
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21. I attended the deceased from **May 3-1948** to **Oct 14-1959** and last saw him alive on **Sept 27-1959**  
Death occurred at **12:30** p.m. on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) <b>Maxwell Ford, M.D.</b>	22b. ADDRESS <b>Elmo Mo.</b>	22c. DATE SIGNED <b>Oct 19 59</b>
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23b. DATE OF BURIAL, CREMATION, REMOVAL (Specify) <b>Burial 10/16/59</b>	23c. NAME OF CEMETERY OR CREMATORY <b>High Prairie Cemetery</b>	23d. LOCATION (City, town, or county) (State) <b>Elmo, Mo.</b>
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24. FUNERAL DIRECTOR <b>P Price Funeral Home, Maryville, Mo.</b>	ADDRESS	25. DATE RECD. BY LOCAL REG. <b>10-19-59</b>	26. REGISTRAR'S SIGNATURE <b>Kess Bolt</b>
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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 me  
or by \_\_\_\_\_, Student Embalmer No. \_\_\_\_\_  
working under my personal supervision.

Student \_\_\_\_\_  
Signature of Student Embalmer

Signed John W. Price  
Licensed Embalmer No. 4281

P. O. Address Maryville

**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.