

MURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

59-037148

FILED VS OCT 21 1959

Registration District No. 278 Primary Registration District No. 3054 Registrar's No. 122.

STATE FILE NUMBER

MEMORIALIZED

1. PLACE OF DEATH a. COUNTY <u>PIKE CO</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>ILLINOIS</u> b. COUNTY <u>COLHOUN</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>LOUISIANA-MO.</u>		c. CITY OR TOWN <u>KAMPSVILLE</u>	
Length of stay in 1b <u>3 DAYS.</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>PIKE CO-HOSPITAL</u>		d. STREET ADDRESS (If outside, give location) <u>RFD. No-1</u>	
Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	

3. NAME OF DECEASED (Type or print) <u>CUBA</u> First <u>ELSIE</u> Middle <u>GRAY</u> Last	4. DATE OF DEATH <u>OCT 15 59</u> Month <u>15</u> Day <u>59</u> Year
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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>1-12-85</u>	9. AGE (last birthday) <u>74</u>	IF UNDER 1 YEAR Months <u>9</u> Days <u>3</u> Hours <u>0</u> Min. <u>0</u>	IF UNDER 24 HR Months <u>0</u> Days <u>0</u> Hours <u>0</u> Min. <u>0</u>
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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 <u>HOME</u>	11. BIRTHPLACE (City and state of country) <u>COLHOUN-ILLINOIS</u>	12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>
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13a. FATHER'S NAME <u>UNKNOWN</u>	13b. MOTHER'S MAIDEN NAME <u>MELISSA-RUSSELL</u>	14. NAME OF HUSBAND OR WIFE <u>VIRGIL GRAY</u>
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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) <u>NO.</u>	16. SOCIAL SECURITY NO. <u>NONE</u>	17. INFORMANT Address <u>Mrs ROY SEVIER. LOUISIANA MO.</u>
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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 <u>6 hrs</u>
IMMEDIATE CAUSE (a) <u>Coronary artery Occlusion</u>	DUE TO (b) <u>Hypertensive Cardiac vascular Disease</u>	<u>5477</u>
DUE TO (c) <u>Disease</u>		

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
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19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20a. ACCIDENT- SUICIDE HOMICIDE <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.) <u>-----</u>
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20c. TIME OF INJURY Hour <u>8:40</u> a.m. <u>0</u> p.m.	Month, Day, Year <u>10/15/59</u>
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20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" 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 10/1959 to 10/15/59 and last saw her alive on 10/15/59
Death occurred at 8:40 A.M. on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) <u>Chas H Lemellen M.D.</u>	22b. ADDRESS <u>Louisiana, Missouri</u>	22c. DATE SIGNED <u>10/16/59</u>
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23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	23b. DATE <u>Oct. 17, 1959</u>	23c. NAME OF CEMETERY OR CREMATORY <u>SUMMIT GROVE</u>	23d. LOCATION (City, town, or county) (State) <u>COLHOUN CO., ILL.</u>
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24. FUNERAL DIRECTOR ADDRESS <u>GEO. M. COLLIER, LOUISIANA, MO</u>	25. DATE RECD BY LOCAL REG. <u>OCT 16-59</u>	26. REGISTRAR'S SIGNATURE <u>Bernice Collier</u>
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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 Geo. M. Callier

Licensed Embalmer No. 3839

P. O. Address Louisiana

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.