

URI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

59-037222

FILED VS NOV 6 1959 294

STATE FILE NUMBER

Registration District No. 294 Primary Registration District No. 3056 Registrar's No. 247

ENDED

1. PLACE OF DEATH a. COUNTY Randolph				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY Randolph					
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Moberly		Length of stay in 1b Over 50 years		c. CITY OR TOWN Moberly		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>			
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Wabash Employes' Hospital			Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location) 420 Union Avenue		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First OPL Middle NADINE Last PULLIAM				4. DATE OF DEATH Month October Day 28 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 2/19/1894	9. AGE (last birthday) 65	IF UNDER 1 YEAR Months _____ Days _____	IF UNDER 24 HR Hours _____ Min. _____		
10. USUAL OCCUPATION (Give kind of work done during most of working life) Cook - Wabash Employes' Hospital.			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (City and state or country) Randolph County		12. CITIZEN OF WHAT COUNTRY U.S.A.		
13a. FATHER'S NAME Jacob Colwell			13b. MOTHER'S MAIDEN NAME Josephine Hardin			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. 491-07-2614		17. INFORMANT William Harley			Address	
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 coronary thrombosis							Immediate		
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.									
DUE TO (b) Gangrene of foot and lower leg (amputation) Rt.							2 weeks		
DUE TO (c) Hypertensive Cardiovascular Disease							Years (?)		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) Myocardial ischemia, severe, Liver dysfunction and Kidney dysfunction.						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			
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.)					
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 Sept. 12, 1959 to Oct. 28, 1959 and last saw her ^{her} alive on October 28, 1959 Death occurred at 8:45 A. M. on the date stated above, and to the best of my knowledge, from the causes stated.									
22a. SIGNATURE McMurry M.D. (Degree or Title) K. McMurry M.D., Surgeon in Charge				22b. ADDRESS Wabash Employes' Hospital Moberly, Missouri			22c. DATE SIGNED 10/28/59		
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE OCT 30, 1959	23c. NAME OF CEMETERY OR CREMATORY OAKLAND			23d. LOCATION (City, town, or county) MOBERLY MO		(State)	
24. FUNERAL DIRECTOR MAHAN FUNERAL SERVICE Moberly Mo				25. DATE RECD. BY LOCAL REG. 10-30-59		26. REGISTRAR'S SIGNATURE Peablowe			

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

6567 9 ADM SA

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 A. Green

Licensed Embalmer No. 3815

P. O. Address Moberly 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.