

URI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

59-037306

FILED VS OCT 16 1959

STATE FILE NUMBER

Registration District No. 314 Primary Registration District No. 4457 Registrar's No. 47

ENDED

1. PLACE OF DEATH a. COUNTY <u>St Clair</u>			2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Mo</u> b. COUNTY <u>St Clair</u>		
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Orcola</u>		Length of stay in 1b <u>3 da</u>	c. CITY OR TOWN <u>Orcola</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>Orcola Medical</u>			Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <u>Waters Rest Home</u>	
3. NAME OF DECEASED (Type or print) First <u>Hoop</u> Middle <u>J.</u> Last <u>Elliott</u>			4. DATE OF DEATH Month <u>Sept</u> Day <u>24</u> Year <u>1959</u>		
5. SEX <u>F</u>	6. COLOR OR RACE <u>w</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>Mar 12 1876</u>	9. AGE (last birthday) <u>83</u>	IF UNDER 1 YEAR Months _____ Days _____ Hours _____ Min. _____
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Wife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>no</u>	11. BIRTHPLACE (City and state or country) <u>Mo</u>		12. CITIZEN OF WHAT COUNTRY
13a. FATHER'S NAME <u>Warren Perkins</u>		13b. MOTHER'S MAIDEN NAME <u>Emma Mulvany</u>		14. NAME OF HUSBAND OR WIFE <u>deceased</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>-</u>	17. INFORMANT <u>Maye Naves Long Beach Calif</u> Address _____		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Vascular accident</u>					INTERVAL BETWEEN ONSET AND DEATH <u>3 da</u>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____					
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	
19. WAS AUTOPSY PERFORMED? YES <input 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 _____ 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 <u>July 1 - 1958</u> to <u>Sept 4 - 59</u> and last saw her <u>9-24-59</u> alive on <u>9-24-59</u> Death occurred at <u>430 A</u> m on the date stated above, and to the best of my knowledge, from the causes stated.					
22a. SIGNATURE (Degree or title) <u>DH Giesler M.D. P.S.</u>			22b. ADDRESS <u>Orcola Mo</u>		22c. DATE SIGNED <u>9-28-59</u>
23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE <u>9-28-59</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Orcola Mo</u>		23d. LOCATION (City, town, or county) (State) <u>Orcola Mo</u>	
24. FUNERAL DIRECTOR <u>Medical Home Service Inc</u>		ADDRESS <u>928-1959</u>		25. DATE RECD. BY LOCAL REG. <u>9-28-1959</u>	26. REGISTRAR'S SIGNATURE <u>Paul Seavers</u>

(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 J. B. Goodrich

Licensed Embalmer No. 3038

P. O. Address Ocean Me

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.