

URI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH
 FILED VS NOV 6 1959

59-037545

STATE FILE NUMBER

Registration District No. _____ Primary Registration District No. _____ Registrar's No. **2 9659**

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Kansas b. COUNTY	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN St. Louis		c. CITY OR TOWN Hoisington	
Length of stay in 1b		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (IF NOT in hospital, give location) HOSPITAL OR INSTITUTION Missouri Pacific Hosp.		d. STREET ADDRESS (If outside, give location) General Delivery	
Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>		Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>	

3. NAME OF DECEASED (Type or print) First Middle Last WILLIE MAE DORSEY			4. DATE OF DEATH Month Day Year October 20, 1959			
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5. SEX Female	6. COLOR OR RACE Colored	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH Jan. 17, 1902	9. AGE (last birthday) 57	IF UNDER 1 YEAR Months 9 Days 3 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) Housewife	10b. KIND OF BUSINESS OR INDUSTRY At Home	11. BIRTHPLACE (City and state or country) Greenville, Miss.	12. CITIZEN OF WHAT COUNTRY U. S. A.
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13a. FATHER'S NAME Henry Griffin	13b. MOTHER'S MAIDEN NAME Eliza Fisher	14. NAME OF HUSBAND OR WIFE Perry Dorsey
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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) No	16. SOCIAL SECURITY NO. None	17. INFORMANT Perry Dorsey, Hoisington, Kansas 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:		INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a) 2nd & 3rd degree burns of 35% of body and face.		916.016
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 immediate cause or disease condition given in PART I (a) Suffered an October 12th 1959 when clothing caught on fire from smoking in bed at home		PART III. If deceased was female was there a pregnancy in last 90 days. <input checked="" 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 <input checked="" type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>	20b. DESCRIBE HOW INJURY ACQUIRED. (Give name of physician in PART II or PART III if from 18.) as a result of smoking in bed at home
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20c. TIME OF INJURY Hour 10 a.m. 12 p.m. 5 p.m.	Month, Day, Year all 14th 1959	20d. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) Home	20f. CITY, TOWN, OR LOCATION St Louis Mo	COUNTY Mo	STATE
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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.) 066 Home	20f. CITY, TOWN, OR LOCATION St Louis Mo	COUNTY Mo	STATE
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21. I attended the deceased from _____, to _____, and last saw her/him alive on _____.
 Death occurred at **4:15** A.m. on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) Patrick Taylor Carraway	22b. ADDRESS 1300 Clark	22c. DATE SIGNED 10.21.59
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23a. BURIAL, CREMATION, REMOVAL (Specify) Removal	23b. DATE Oct. 21, 1959	23c. NAME OF CEMETERY OR CREMATORY Live Oak Cemetery	23d. LOCATION (City, town, or county) (State) Greenville, Mississippi
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24. FUNERAL DIRECTOR Ambruster Mortuary, 6633 Clayton Rd.	25. DATE RECD. BY LOCAL REG. OCT 21 1959	26. REGISTRAR'S SIGNATURE Earl Smith, M.D.
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DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

mrb

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 Paul J. Turner

Licensed Embalmer No. 4788

P. O. Address St. Louis 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.