

JURISDICTION OF HEALTH - STANDARD CERTIFICATE OF DEATH
FILED VS NOV 6 1959

59-038008

2 9899

STATE FILE NUMBER

Registration District No. _____ Primary Registration District No. _____ Registrar's No. _____

EMENDED

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY Howell			
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN St. Louis		Length of stay in 1b 6 days		c. CITY OR TOWN West Plains Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION DePaul Hospital		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location) Gainesville Route Reside on Farm Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Willie			4. DATE OF DEATH Month October Day 27 Year 1959		
5. SEX Female	6. COLOR OR RACE White	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH 7/19/1891	9. AGE (last birthday) 68	IF UNDER 1 YEAR Months _____ Days _____
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) Arkansas.	12. CITIZEN OF WHAT COUNTRY U.S.A.		
13a. FATHER'S NAME John Ferniman		13b. MOTHER'S MAIDEN NAME Helen Birchett		14. NAME OF HUSBAND OR WIFE Ray Risner	
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. Nil	17. INFORMANT Genevieve Johnson, 39 No. Margurite, Ferguson, Missouri 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) Arteriosclerotic Heart Disease					INTERVAL BETWEEN ONSET AND DEATH 4 hrs
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____					4200
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) Toxic gastritis.				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 3-2-59 to 10-27-59 and last saw ^{her} him alive on 10-26-59 Death occurred at 6:50 A m on the date stated above, and to the best of my knowledge, from the causes stated.					
22a. SIGNATURE R. Cogleman, MD (Degree or title)			22b. ADDRESS St. Louis 35, Mo.		22c. DATE SIGNED 10/27/59 (State)
23a. BURIAL, CREMATION, REMOVAL (Specify) Removal	23b. DATE 10/27/59	23c. NAME OF CEMETERY OR CREMATORY West Plains Memorial	23d. LOCATION (City, town, or county) West Plains, Missouri.		
24. FUNERAL DIRECTOR Albert H. Hoppe, Inc., 1700 Washington ADDRESS		25. DATE RECD. BY LOCAL REG. OCT 28 1959	26. REGISTRAR'S SIGNATURE Earl Smith, M.D. S.P.		

DOCUMENT

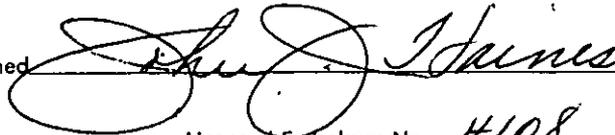
MEDICAL CERTIFICATION

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  _____

Licensed Embalmer No. 4108

P. O. Address St Louis

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.