

**DEPARTMENT OF HEALTH - STANDARD CERTIFICATE OF DEATH**

**59-038676**

STATE FILE NUMBER

FILED VS OCT 20 1959

Registration District No. 356 Primary Registration District No. 4521 Registrar's No. 86

UNDECEASED

1. PLACE OF DEATH a. COUNTY <u>Texas</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Texas</u>			
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Houston</u>		Length of stay in 1b <u>8 das.</u>		c. CITY OR TOWN <u>Morris Twp #1</u>		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>Texas County Mem. Hospital</u>				Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside/give location) Reside on Farm Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Eula</u> Middle <u>Ellen</u> Last <u>Burch</u>				4. DATE OF DEATH Month <u>10</u> Day <u>10</u> Year <u>1959</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>white</u>		7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>		8. DATE OF BIRTH <u>9-4-1909</u>	
9. AGE (last birthday) <u>50</u>		IF UNDER 1 YEAR Months _____ Days _____		IF UNDER 24 HR Hours _____ Min. _____			
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>Upton, Missouri</u>		12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>	
13a. FATHER'S NAME <u>James L. Ragain</u>				13b. MOTHER'S MAIDEN NAME <u>Fronie Adams</u>		14. NAME OF HUSBAND OR WIFE <u>FRANK</u>	
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>497-32-8882</u>		17. INFORMANT <u>FRANK Burch - Bucyrus, Mo.</u>	
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>adenocarcinoma of colon</u> DUE TO (b) _____ DUE TO (c) _____ Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.						INTERVAL BETWEEN ONSET AND DEATH <u>10 mo.</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 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 <u>Feb 1959</u> to <u>Oct 9, 1959</u> and last saw her/him alive on <u>Oct 9, 1959</u> Death occurred at <u>4:30 a.m.</u> on the date stated above, and to the best of my knowledge, from the causes stated.							
22a. SIGNATURE (Degree or title) <u>David H. Wilbur M.D.</u>				22b. ADDRESS <u>Cabool, Mo.</u>		22c. DATE SIGNED <u>10/16/59</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE <u>10-13-59</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Dykes Cemetery</u>		23d. LOCATION (City, town, or county) (State) <u>Texas County, Missouri</u>	
24. FUNERAL DIRECTOR <u>Raymond E. Duff - Houston, Mo.</u>				25. DATE RECD. BY LOCAL REG. <u>10-17-59</u>		26. REGISTRAR'S SIGNATURE <u>Myrtle Craig</u>	

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 Frank E. Wood

Licensed Embalmer No. 4024

P. O. Address Houston, TX

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.