

URI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

59-038741

FILED VS. OCT. 1, 1959

STATE FILE NUMBER

Registration District No. 79 Primary Registration District No. 4553 Registrar's No. 24

ENDED

| | | | | | | | |
|---|---|---|--|--|---|---|---|
| 1. PLACE OF DEATH a. COUNTY <u>WRIGHT</u> | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MO.</u> b. COUNTY <u>WRIGHT</u> | | | |
| b. CITY (If outside corporate limits, give TOWNSHIP only) <u>MANSFIELD</u> | | Length of stay in 1b <u>YEARS</u> | | c. CITY OR TOWN <u>MANSFIELD</u> | | Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> | |
| c. FULL NAME OF (If NOT in hospital, give location) <u>MANSFIELD HOSPITAL</u> | | | Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> | d. STREET ADDRESS (If outside, give location) <u>—</u> | | | Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> |
| 3. NAME OF DECEASED (Type or print) First <u>ELLA</u> Middle <u>NORA</u> Last <u>CRAIG</u> | | | | 4. DATE OF DEATH Month <u>Sept.</u> Day <u>25</u> Year <u>1959</u> | | | |
| 5. SEX <u>F</u> | 6. COLOR OR RACE <u>W</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>AUG. 10, 1898</u> | 9. AGE (last birthday) <u>81</u> | IF UNDER 1 YEAR Months <u>—</u> Days <u>—</u> | IF UNDER 24 HR Hours <u>—</u> Min. <u>—</u> |
| 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>—</u> | | 11. BIRTHPLACE (City and state or country) <u>Webster County Mo.</u> | | 12. CITIZEN OF WHAT COUNTRY <u>U. S. A.</u> |
| 13a. FATHER'S NAME <u>John Stinnett</u> | | | 13b. MOTHER'S MAIDEN NAME <u>Evelyn Simpkins</u> | | 14. NAME OF HUSBAND OR WIFE <u>NOAH J.</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>NONE</u> | | 17. INFORMANT <u>Irene Hicks</u> Address <u>MANSFIELD Mo.</u> | | |
| 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 <u>3 days</u> | |
| IMMEDIATE CAUSE (a) <u>Hypostatic Pneumonia</u> | | | | | | | |
| Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. | | | | | | DUE TO (b) <u>Complications of old age</u> | |
| | | | | | | DUE TO (c) <u>—</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 <u>—</u> a.m. <u>—</u> p.m. <u>—</u> | Month <u>—</u> Day <u>—</u> Year <u>—</u> | | | | | | |
| 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>May 4, 1959</u> to <u>Sept. 25, 1959</u> and last saw her/him alive on <u>Sept. 25, 1959</u> | | | | | | | |
| Death occurred at <u>11:50</u> P. on the date stated above, and to the best of my knowledge, from the causes stated. | | | | | | | |
| 22a. SIGNATURE (Disease or other) <u>Dr. Newton D. Crawford</u> | | | 22b. ADDRESS <u>Mansfield Mo.</u> | | | 22c. DATE SIGNED <u>9-28-59</u> | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u> | 23b. DATE <u>Sept. 29, 1959</u> | 23c. NAME OF CEMETERY OR CREMATORY <u>MANSFIELD</u> | | 23d. LOCATION (City, town, or county) (State) <u>MANSFIELD MO.</u> | | | |
| 24. FUNERAL DIRECTOR <u>Max & Miller</u> ADDRESS <u>Mansfield Mo.</u> | | | 25. DATE RECD. BY LOCAL REG. <u>Oct. 5-59</u> | | 26. REGISTRAR'S SIGNATURE <u>—</u> | | |

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

1299 20 47 2
13
STEWART
MILLER

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 Max L Miller

Licensed Embalmer No. 4720

P. O. Address Manofield

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.