

URI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

59-038801

STATE FILE NUMBER

FILED VS. DEC 7 1959

Registration District No. 2 Primary Registration District No. 5016 Registrar's No. 70

ENDED

1. PLACE OF DEATH				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)				
a. COUNTY <u>Andrew</u>		b. CITY (If outside corporate limits, give TOWNSHIP only) <u>Lincoln Township</u>		a. STATE <u>Missouri</u> b. COUNTY <u>Andrew</u>		c. CITY OR TOWN <u>Amazonia</u>		
b. CITY (If outside corporate limits, give TOWNSHIP only) <u>Lincoln Township</u>		Length of stay in 1b OR TOWN <u>most of life</u>		c. CITY OR TOWN <u>Amazonia</u>		Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>		
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>Amazonia, Mo., Rt. # 1</u>		Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>		d. STREET ADDRESS (If outside, give location) <u>Route # 1</u>		Reside on Farm Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First <u>CELIA</u> Middle <u>LEOLA</u> Last <u>MC ARTHUR</u>				4. DATE OF DEATH Month <u>November</u> Day <u>22</u> Year <u>1959</u>				
5. SEX <u>Female</u>		6. COLOR OR RACE <u>Caucasian</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>8/16/1893</u>		
9. AGE (last birthday) <u>66 yrs.</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>of the home</u>		11. BIRTHPLACE (City and state or country) <u>Oregon, Missouri</u>		12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>	
13a. FATHER'S NAME <u>Thomas Hughes</u>			13b. MOTHER'S MAIDEN NAME <u>Emaline Gillenwater</u>			14. NAME OF HUSBAND OR WIFE <u>Archie M. McArthur</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>Archie M. McArthur, Amazonia, Mo.</u> Address <u>Rt. #1</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	
IMMEDIATE CAUSE (a) <u>Myocardial Infarction</u>							<u>10 min.</u>	
DUE TO (b) <u>Arteriosclerotic Heart Disease</u>							<u>unknown</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 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>		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, 1953</u> to <u>Nov. 22, 1959</u> and last saw her alive on <u>Nov. 22, 1959</u> Death occurred at <u>8:55 P.m.</u> on the date stated above, and to the best of my knowledge, from the causes stated.								
22a. SIGNATURE <u>J. J. Sullivan, M.D.</u> (Degree or title)				22b. ADDRESS <u>Oregon, Mo.</u>		22c. DATE SIGNED		
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>		23b. DATE <u>11/25/1959</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Highland Cemetery</u>		23d. LOCATION (City, town, or county) (State) <u>East of Oregon, Missouri</u>			
24. FUNERAL DIRECTOR <u>Stoney Funeral Home (GAS)</u> ADDRESS <u>St. Joseph, Mo.</u>			25. DATE RECD. BY LOCAL REG. <u>12-4-59</u>		26. REGISTRAR'S SIGNATURE <u>Lillian Spauld</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 Charles E. Bennett

Licensed Embalmer No. 4677

P. O. Address St Joseph 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.