

JURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

59-039264

FILED VS DEC 4 1959

STATE FILE NUMBER

Registration District No. 58 Primary Registration District No. 5217 Registrar's No. 29

UNRECORDED

1. PLACE OF DEATH		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)	
a. COUNTY <u>CARTER Johnson T.</u>	a. STATE <u>MISSOURI</u> b. COUNTY <u>CARTER</u>		
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>GRANDIN</u>	Length of stay in 1b <u>8 yrs.</u>	c. CITY OR TOWN <u>GRANDIN</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>1/2 mile E. GRANDIN</u>	Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <u>1/2 mile E. GRANDIN</u>	Reside on Farm Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>

3. NAME OF DECEASED (Type or print)	First <u>Isabelle</u> Middle <u>Louise</u> Last <u>GRAHAM</u>	4. DATE OF DEATH	Month <u>Nov.</u> Day <u>20</u> Year <u>1959</u>
--	---	-------------------------	--

5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <u>April 15 1902</u>	9. AGE (last birthday) <u>57</u>	IF UNDER 1 YEAR	IF UNDER 24 HR
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>Home</u>	11. BIRTHPLACE (City and state or country) <u>Clarksville, Iowa</u>	12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>		

13a. FATHER'S NAME <u>William Witt</u>	13b. MOTHER'S MAIDEN NAME <u>Augusta Hobberman</u>	14. NAME OF HUSBAND OR WIFE <u>-</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>Robert Graham</u> Address <u>Grandin, 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>15 mins</u>
IMMEDIATE CAUSE (a) <u>Acute Circulatory Failure</u>	
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 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 _____ 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.) <u>Died on arrival</u>	20f. CITY, TOWN, OR LOCATION _____ COUNTY _____ STATE _____
---	--	--

21. I attended the deceased from Died on arrival **to** _____ **and last saw her/him alive on** _____
Death occurred at _____ **on the date stated above, and to the best of my knowledge, from the causes stated.**

22a. SIGNATURE (Degree or title) <u>Colman McQueen Curran</u>	22b. ADDRESS <u>New Braun, Mo</u>	22c. DATE SIGNED <u>11-24-59</u>
--	--	---

23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	23b. DATE <u>Nov 25, 1959</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Grandin Cemetery</u>	23d. LOCATION (City, town, or county) (State) <u>CARTER COUNTY, MO.</u>
--	--------------------------------------	---	--

24. FUNERAL DIRECTOR <u>Edwards Funeral Home</u> ADDRESS <u>Doniphan, Mo.</u>	25. DATE RECD. BY LOCAL REG. <u>Dec. 1st - 59</u>	26. REGISTRAR'S SIGNATURE <u>Mrs Oeta Hanson</u>
--	--	---

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

STATE OF MISSISSIPPI
DEPARTMENT OF HEALTH
DIVISION OF PUBLIC HEALTH
EMBALMERS

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 *Gene Starnes*

Licensed Embalmer No. *4809*

P. O. Address *Naylor, MS*

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.