

DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

59-039309

FILED VS NOV 16 1959

STATE FILE NUMBER

Registration District No. 64 Primary Registration District No. 5245 Registrar's No. 58

1. PLACE OF DEATH a. COUNTY <u>Chariton</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Mo</u> b. COUNTY <u>Chariton</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Keytesville Twp.</u>	Length of stay in 1b <u>5 yrs -</u>	c. CITY OR TOWN <u>Salisbury</u>	Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>Chariton Co. Rest Home</u>		d. STREET ADDRESS (If outside, give location)	Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print) First <u>Frank</u> Middle <u>Mitch</u> Last <u>Mitch</u>			4. DATE OF DEATH Month <u>11</u> Day <u>3</u> Year <u>59</u>		
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</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>7-29-1878</u>	9. AGE (last birthday) <u>81</u>	IF UNDER 1 YEAR Months <u>3</u> Days <u>4</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Retired</u>	11. BIRTHPLACE (City and state or country) <u>Macon, Co Mo</u>	12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>	
13a. FATHER'S NAME <u>Unknown</u>		13b. MOTHER'S MAIDEN NAME <u>Unknown</u>		14. NAME OF HUSBAND OR WIFE <u>Effie. (dec)</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>Leaveell Mitch Kapate, 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
IMMEDIATE CAUSE (a)	<u>Acute Nephritis</u>	
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) <u>Senility</u> <u>Been in Bed 3 years</u> 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	
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19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input 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>7:45</u> Month, Day, Year <u>1958</u> a.m. p.m.	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 <u>Brunswick MO</u>

21. I attended the deceased from 1958 to Oct 31st and last saw him alive on Oct .31st - 59
Death occurred at 7:45 A m on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE <u>J. L. Fisher D.D.</u>	(Degree or title)	22b. ADDRESS <u>Brunswick MO</u>	22c. DATE SIGNED <u>Nov 3 - 59</u>
23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE <u>11-5-59</u>	23c. NAME OF CEMETERY OR CREMATORY <u>North Hill</u>	23d. LOCATION (City, town, or county) <u>Marceline Mo</u>

24. FUNERAL DIRECTOR <u>James McLaughlin</u>	ADDRESS <u>marceline, mo</u>	25. DATE RECD. BY LOCAL REG. <u>11-9-59</u>	26. REGISTRAR'S SIGNATURE <u>J. W. Hawkins</u>
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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 _____ or by _____, Student Embalmer No. _____ working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed James B. Mc Clellan

Licensed Embalmer No. 4230

P. O. Address Brooklyn

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to sign 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.