

MURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

59-039583

FILED VS DEC 15 1959

STATE FILE NUMBER

Registration District No. 112 Primary Registration District No. 5429 Registrar's No. 19

UNRECORDED

| | | | | | | | | | | | | | |
|--|--|--|--|--|--|---|--|---|--|--|--|---|--|
| 1. PLACE OF DEATH a. COUNTY <u>Franklin</u> b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Lyon</u> Length of stay in lb <u>4 yrs</u> c. FULL NAME OF DECEASED (NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>Beaufort Mo RHR</u> Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Mo</u> b. COUNTY <u>Franklin</u> c. CITY OR TOWN <u>Beaufort Mo RHR</u> Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> d. STREET ADDRESS (If outside, give location) <u>✓</u> Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/> | | | | | | | | | |
| 3. NAME OF DECEASED (Type or print) First <u>Eveline</u> Middle <u>M.</u> Last <u>Spelton</u> | | | | 4. DATE OF DEATH Month <u>Dec</u> Day <u>11</u> Year <u>1959</u> | | | | | | | | | |
| 5. SEX <u>F</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>11/24/84</u> | | 9. AGE (last birthday) <u>75-0-17</u> | | IF UNDER 1 YEAR Months Days Hours Min. | | 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 | | | | 11. BIRTHPLACE (City and state or country) <u>Tennessee.</u> | | 12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u> | | | |
| 13a. FATHER'S NAME <u>Unknown.</u> | | | | 13b. MOTHER'S MAIDEN NAME <u>Sallye Hudson.</u> | | | | 14. NAME OF HUSBAND OR WIFE | | | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <input checked="" type="checkbox"/> (If yes, give war or dates of service) | | | | 16. SOCIAL SECURITY NO. <u>no</u> | | 17. INFORMANT Address <u>Mrs Arletia Borgman Beaufort 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>Coronary Occlusion</u> DUE TO (b) <u>Arteriosclerosis</u> DUE TO (c) <u>Coronary Sclerosis, arterial</u> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. | | | | | | | | | | | | INTERVAL BETWEEN ONSET AND DEATH <u>2nd day</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 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. Month, Day, 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>1957</u> , to <u>11-14-59</u> and last saw her alive on <u>11-14-59</u> Death occurred at <u>Home</u> <u>6 A</u> m on the date stated above, and to the best of my knowledge, from the causes stated. | | | | | | | | | | | | | |
| 22a. SIGNATURE (Degree or title) <u>Charles Spelton MD</u> | | | | | | | | 22b. ADDRESS <u>Harold</u> | | 22c. DATE SIGNED <u>12-11-59</u> (State) <u>Mo</u> | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) | | 23b. DATE <u>Dec 13, 1959</u> | | 23c. NAME OF CEMETERY OR CREMATORY <u>Steele Cemetery</u> | | 23d. LOCATION (City, town, or county) <u>Steele</u> | | | | | | | |
| 24. FUNERAL DIRECTOR <u>E H Lemme</u> ADDRESS <u>Beaufort Mo</u> | | | | 25. DATE RECD. BY LOCAL REG. <u>Dec 11-1959</u> | | 26. REGISTRAR'S SIGNATURE <u>John Charles Fentley</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 E H Lemme, Student Embalmer No. _____
working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed E H Lemme

Licensed Embalmer No. 3076

P. O. Address _____

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.