

# URI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

59-039817

STATE FILE NUMBER

139

FILED VS DEC 7 1959

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Registration District No. \_\_\_\_\_ Primary Registration District No. \_\_\_\_\_ Registrar's No. \_\_\_\_\_

ENDED

<b>1. PLACE OF DEATH</b> a. COUNTY <b>Holt</b>		<b>2. USUAL RESIDENCE</b> (Where deceased lived. If institution: Residence before admission) a. STATE <b>Missouri</b> COUNTY <b>Holt</b>		
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>Skidmore - rural</b>		Length of stay in 1b <b>13 years</b>	c. CITY OR TOWN <b>Skidmore</b>	Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>Family home</b>		Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <b>4 miles southwest</b>	Reside on Farm Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>

<b>3. NAME OF DECEASED</b> (Type or print) First <b>LOUIE</b> Middle <b>ELIZABETH</b> Last <b>IRWIN</b>			<b>4. DATE OF DEATH</b> Month <b>11</b> Day <b>23</b> Year <b>59</b>			
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<b>5. SEX</b> Female	<b>6. COLOR OR RACE</b> White	<b>7. Married</b> <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	<b>8. DATE OF BIRTH</b> <b>10/16/14</b>	<b>9. AGE (last birthday)</b> <b>45</b>	IF UNDER 1 YEAR Months _____ Days _____	IF UNDER 24 HR Hours _____ Min. _____	
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<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <b>housewife</b>		<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <b>Own home</b>		<b>11. BIRTHPLACE</b> (City and state or country) <b>Riverton, Nebr.</b>		<b>12. CITIZEN OF WHAT COUNTRY</b> <b>USA</b>	
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<b>13a. FATHER'S NAME</b> <b>William Francis Day</b>		<b>13b. MOTHER'S MAIDEN NAME</b> <b>Edna Ola Willis</b>		<b>14. NAME OF HUSBAND OR WIFE</b> <b>O. B. Irwin</b>	
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<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) (If yes, give war or dates of service) <b>no</b>		<b>16. SOCIAL SECURITY NO.</b> <b>none</b>		<b>17. INFORMANT</b> Address <b>O. B. Irwin, Skidmore, Mo.</b>	
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<b>18. CAUSE OF DEATH</b> (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute Myocardial Infarction - dilatation</b> DUE TO (b) <b>Probable Acute Pulmonary infarction</b> DUE TO (c) _____ Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.		INTERVAL BETWEEN ONSET AND DEATH <b>1 hour</b>  <b>1 hour</b>
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PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <b>Hysterectomy Nov 10, 1959</b>		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	
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<b>19. WAS AUTOPSY PERFORMED?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	<b>20a. ACCIDENT</b> <input type="checkbox"/> <b>SUICIDE</b> <input type="checkbox"/> <b>HOMICIDE</b> <input checked="" type="checkbox"/>	<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in PART I or PART II of item 18.)	
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<b>20c. TIME OF INJURY</b> Hour _____ Month, Day, Year _____ a.m. _____ p.m. _____		
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<b>20d. INJURY OCCURRED WHILE AT WORK</b> <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>	<b>20e. PLACE OF INJURY</b> (e.g., in or about home, farm, factory, street, office bldg., etc.)	<b>20f. CITY, TOWN, OR LOCATION</b> COUNTY STATE	
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<b>21. I attended the deceased from</b> _____ <b>11/23/59</b> and last saw her <input checked="" type="checkbox"/> alive on <b>11/23/59</b> Death occurred at <b>0:45</b> A. M. on the date stated above, and to the best of my knowledge, from the causes stated.	
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<b>22a. SIGNATURE</b> (Degree or title) <b>W.R. Jackson M. D.</b>		<b>22b. ADDRESS</b> <b>Maryville, Missouri</b>	<b>22c. DATE SIGNED</b> <b>12/2/59</b>
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<b>23a. BURIAL, CREMATION, REMOVAL (Specify)</b> <b>burial</b>	<b>23b. DATE</b> <b>11/25/59</b>	<b>23c. NAME OF CEMETERY OR CREMATORY</b> <b>Hillcrest</b>	<b>23d. LOCATION</b> (City, town, or county) (State) <b>Skidmore, Missouri</b>	
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<b>24. FUNERAL DIRECTOR</b> ADDRESS <b>Price Funeral Home, Maryville, Mo.</b>		<b>25. DATE RECD. BY LOCAL REG.</b> <b>12/4/1959</b>	<b>26. REGISTRAR'S SIGNATURE</b> 	
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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 me  
or by \_\_\_\_\_, Student Embalmer No. \_\_\_\_\_  
working under my personal supervision.

Student \_\_\_\_\_  
Signature of Student Embalmer

Signed Clum M. Price

Licensed Embalmer No. 1822

P. O. Address Maryville, Tenn.

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.