

MURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

59-040768

FILED VS. DEC 8 1959 170

Registration District No. 3033 Primary Registration District No. 184 Registrar's No. 184

STATE FILE NUMBER

RECEIVED

1. PLACE OF DEATH a. COUNTY <u>Laclede.</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>MILLER</u>									
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>LEBANON</u>		Length of stay in lb <u>1 1/2 yrs</u>		c. CITY OR TOWN <u>OLEAN</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>Longs-Nursing-Home</u>			Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location) <u>5-mi-E-OLEAN</u>		Reside on Farm Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>						
3. NAME OF DECEASED (Type or print) First Middle Last <u>Louis-Cummings-Russell</u>				4. DATE OF DEATH Month Day Year <u>Nov-28-1959</u>									
5. SEX <u>MALE</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>25 Feb-1869</u>		9. AGE (last birthday) <u>90</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>Farmer-Stockman</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Gen-Farming</u>				11. BIRTHPLACE (City and state or country) <u>Miller-Co-Mo</u>		12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>			
13a. FATHER'S NAME <u>Buckner-Russell</u>				13b. MOTHER'S MAIDEN NAME <u>MARtha-CLARK</u>				14. NAME OF HUSBAND OR WIFE <u>EMMA-CLAY-Russell</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 Address <u>DELLA-Williams- ELDON 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>Chronic myocarditis</u>										<u>5 days</u>			
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <u>arteriosclerotic heart dis.</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					
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.) <u>NONE</u>									
20c. TIME OF INJURY Hour Month, Day, Year a.m. p.m. <u>NONE</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.) <u>NONE</u>		20f. CITY, TOWN, OR LOCATION <u>NONE</u>		COUNTY		STATE			
21. I attended the deceased from <u>Sept. 1958</u> to <u>Nov. 28, 1959</u> and last saw him alive on <u>11-26-59</u> Death occurred at <u>7:45 A.M.</u> on the date stated above, and to the best of my knowledge, from the causes stated.													
22a. SIGNATURE (Degree or title) <u>B.B. Hurst, M.D.</u>						22b. ADDRESS <u>LEBANON-Missouri</u>			22c. DATE SIGNED <u>30 Nov-1959</u>				
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE <u>30 Nov-1959</u>		23c. NAME OF CEMETERY OR CREMATORY <u>MOUNT-PLEASANT</u>		23d. LOCATION (City, town, or county) <u>MILLER-Co</u>		STATE <u>Mo</u>					
24. FUNERAL DIRECTOR ADDRESS <u>Keith McKays ELDON-Mo</u>				25. DATE RECD. BY LOCAL REG. <u>11-30-1959</u>		26. REGISTRAR'S SIGNATURE <u>DeLLa L. CLay</u>							

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

Heist -

Admission - account for Court House -

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

Keith M. Kays

Licensed Embalmer No. *3998*

P. O. Address *Eldon 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.