

URI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

59-040945

FILED VS DEC 15 1959

STATE FILE NUMBER

Registration District No. 100 Primary Registration District No. \_\_\_\_\_ Registrar's No. 209

ENDED

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| 1. PLACE OF DEATH<br>a. COUNTY <b>Macon</b>   |  | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <b>Tenn.</b> b. COUNTY <b>Unknown</b> |  |
| b. CITY (If outside corporate limits, give TOWNSHIP only)<br><b>Hudson</b>  |  | Length of stay in lb<br><b>7 yr. 4 mo 22 days</b>   | c. CITY OR TOWN <b>Chattanooga</b><br>Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>                    |
| c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION<br><b>Still-Hildreth Osteopathic Hospital</b> |  | Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>   | d. STREET ADDRESS (If outside, give location)<br><b>Unknown</b><br>Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/> |

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| 3. NAME OF DECEASED (Type or print)<br>First <b>Mary</b> Middle <b>Elizabeth</b> Last <b>Yowell</b> |  |  | 4. DATE OF DEATH<br>Month <b>December</b> Day <b>4</b> Year <b>1959</b> |  |  |
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|-----------------|---------------------------|---|-----------------------------------|----------------------------------|--|--|
| 5. SEX <b>F</b> | 6. COLOR OR RACE <b>W</b> | 7. Married <input type="checkbox"/> Never Married <input checked="" type="checkbox"/><br>Widowed <input type="checkbox"/> Divorced <input type="checkbox"/> | 8. DATE OF BIRTH <b>11/7/1875</b> | 9. AGE (last birthday) <b>84</b> | IF UNDER 1 YEAR<br>Months _____ Days _____ | IF UNDER 24 HR<br>Hours _____ Min. _____ |
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| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Doctor of Osteopathy</b> | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>Doctor of Osteopathy</b> | 11. BIRTHPLACE (City and state or country)<br><b>Queen City, Mo.</b> | 12. CITIZEN OF WHAT COUNTRY<br><b>US</b> |
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| 13a. FATHER'S NAME<br><b>James Yowell</b> | 13b. MOTHER'S MAIDEN NAME<br><b>Farmer</b> | 14. NAME OF HUSBAND OR WIFE<br><b>—</b> |
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| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)<br><b>No</b> | 16. SOCIAL SECURITY NO.<br><b>No.</b> | 17. INFORMANT Address<br><b>Hospital Records.</b> |
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| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Congestive Circulatory Failure</b> | INTERVAL BETWEEN ONSET AND DEATH<br><b>7 days</b> |
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| Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. | DUE TO (b) <b>Prolonged Recumbrance Necessitated by Fracture of the Neck of Left Femur</b> | <b>3 yrs.</b> |
|  | DUE TO (c) <b>Arteriosclerosis</b>   | <b>7 yrs.</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) | PART III. If deceased was female was there a pregnancy in last 90 days.<br><input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown |
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| 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.) |
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| 20c. TIME OF INJURY<br>Hour _____ a.m. _____ p.m.<br>Month, Day, Year _____ |
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| 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<br><b>Macon, Missouri</b> | COUNTY _____ STATE _____ |
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| 21. I attended the deceased from <b>Sept. 1, 1958</b> to <b>Dec. 4, 1959</b> and last saw her/him alive on <b>Dec. 4, 1959</b><br>Death occurred at <b>10:25 a.m.</b> m on the date stated above, and to the best of my knowledge, from the causes stated. |
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| 22a. SIGNATURE<br><b>J. D. Perkins D.D.</b> (Degree or title) | 22b. ADDRESS<br><b>Macon, Missouri</b> | 22c. DATE SIGNED<br><b>12/4/59</b> |
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| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b> | 23b. DATE<br><b>Dec. 6, 1959</b> | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Tell Cemetary</b> | 23d. LOCATION (City, town, or county)<br><b>Greentop, Mo.</b> |
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| 24. FUNERAL DIRECTOR<br><b>Jack Duley</b> | ADDRESS<br><b>Queen City, Mo.</b> | 25. DATE RECD. BY LOCAL REG.<br><b>12/17/59</b> | 26. REGISTRAR'S SIGNATURE<br><b>Walter M. Neely</b> |
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(Licensed Embalmer's Statement on Reverse Side)

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 Charles L. Hutton

Licensed Embalmer No. 4577

P. O. Address Nacow, 1

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.