

MURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

59-041061

FILED VS DEC 7 1959

234

Primary Registration District No. 4349

Registrar's No. 6

STATE FILE NUMBER

MADE

1. PLACE OF DEATH a. COUNTY <u>MORGAN</u> b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>STOVER</u> Length of stay in 1b <u>5 YRS</u> c. FULL NAME OF (IF NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>3 RD. STREET</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MISSOURI</u> b. COUNTY <u>MORGAN</u> c. CITY OR TOWN <u>STOVER</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> d. STREET ADDRESS (if outside, give location) <u>3RD. STREET</u> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
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3. NAME OF DECEASED (Type or print) First <u>ALICE</u> Middle <u>MAE</u> Last <u>DRURY</u>			4. DATE OF DEATH Month <u>NOV.</u> Day <u>27</u> Year <u>1959</u>				
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <u>OCT. 10 1937</u>	9. AGE (last birthday) <u>22</u>	IF UNDER 1 YEAR Months <u>1</u> Days <u>17</u> Hours <u></u> Min. <u></u>		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>MACHINE OPERATOR</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>PANTS FACTORY</u>		11. BIRTHPLACE (City and state or country) <u>PERORIA ILL</u>		12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>	
13a. FATHER'S NAME <u>V.R. THOMPSON</u>		13b. MOTHER'S MAIDEN NAME <u>BLANCH GAHE</u>		14. NAME OF HUSBAND OR WIFE <u>BYOD DRURY</u>			
15. WAS DECEASED EVER IN U.S. ARMED SERVICES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>NO</u>		16. SOCIAL SECURITY NO. <u>489-405664</u>		17. INFORMANT <u>Byod Drury</u> Address <u>STOVER 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>Acute Interstitial Myocarditis</u> DUE TO (b) <u>Upper Respiratory Infection, Virus.</u> DUE TO (c) _____ Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.		INTERVAL BETWEEN ONSET AND DEATH <u>1 Day.</u> <u>3 Days.</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>Viral Meningitis</u>		PART III. If deceased was female was there a pregnancy in last 90 days. <input checked="" 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.)	
20c. TIME OF INJURY Hour _____ a.m. _____ p.m. Month, Day, Year _____		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 Not Attended. to _____ and last saw her/him alive on _____
 Death occurred at 7:30 AM on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree if 11/12) <u>Edward C. Koppa D.O.</u>		22b. ADDRESS <u>Stover, Mo</u>		22c. DATE SIGNED <u>11/30/59</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE <u>NOV. 30 1959</u>		23c. NAME OF CEMETERY OR CREMATORY <u>STOVER CEMETERY</u>	
23d. LOCATION (City, town, or county) (State) <u>STOVER Mo.</u>		24. FUNERAL DIRECTOR ADDRESS <u>J. L. Hewman Stover Mo.</u>		25. DATE RECD. BY LOCAL REG. <u>Dec. 1st 1959</u>	
26. REGISTRAR'S SIGNATURE <u>Wm. L. Ripperger</u>					

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

VS DEC 7 1959

MAR 11 1960

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 J. H. Stevenson

Licensed Embalmer No. 407

P. O. Address Stover 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.