

URI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

59-041302

FILED VS NOV 24 1959 282

STATE FILE NUMBER

Registration District No. Primary Registration District No. Registrar's No. 130

ENDED

1. PLACE OF DEATH a. COUNTY <u>Polk</u> b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Humansville</u> Length of stay in 1b c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>Dimmitt Mem. Hosp.</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>Cedar</u> c. CITY OR TOWN <u>Stockton</u> Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> d. STREET ADDRESS (If outside, give location) <u>3 Miles East</u> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>											
3. NAME OF DECEASED (Type or print) First <u>AMY</u> Middle <u>MYRTLE</u> Last <u>CAMPBELL</u>				4. DATE OF DEATH Month <u>Nov.</u> Day <u>9</u> Year <u>1959</u>											
5. SEX <u>Female</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>3/14/1874</u>		9. AGE (last birthday) <u>85</u>		IF UNDER 1 YEAR Months <u>7</u> Days <u>25</u> Hours <u></u> Min. <u></u>		IF UNDER 24 HR Hours <u></u> Min. <u></u>			
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 <u>Own Home</u>				11. BIRTHPLACE (City and state or country) <u>Stockton, Mo.</u>				12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>			
13a. FATHER'S NAME <u>John T. Owen</u>				13b. MOTHER'S MAIDEN NAME <u>Belle Kirkpatrick</u>				14. NAME OF HUSBAND OR WIFE <u></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></u>				17. INFORMANT Address <u>Mrs. Sylvia Wollard, Stockton, 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 artery Thrombosis</u> DUE TO (b) <u></u> DUE TO (c) <u></u> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.												INTERVAL BETWEEN ONSET AND DEATH <u></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 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 <u></u> a.m. <u></u> p.m. <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>10/28/59</u> to <u>11/9/59</u> and last saw her <u>11/9/59</u> Death occurred at <u>8:30 p.m.</u> on the date stated above, and to the best of my knowledge, from the causes stated.															
22a. SIGNATURE <u>G. G. Robinson</u> (Degree or title) <u>M.D.</u>						22b. ADDRESS <u>Humansville, Mo.</u>				22c. DATE SIGNED <u>11/14/59</u> (State)					
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE <u>11/11/1959</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Stockton City Cemetery</u>				23d. LOCATION (City, town, or county) (State) <u>Stockton, Mo.</u>							
24. FUNERAL DIRECTOR ADDRESS <u>Canton Fun. Home, Stockton, Mo.</u>				25. DATE RECD. BY LOCAL REG. <u>Nov. 20, 1959</u>		26. REGISTRAR'S SIGNATURE <u>Ralph Gordon per Jewell Gordon</u>									

(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 John C. Cantler

Licensed Embalmer No. 4387

P. O. Address Stockton, M.

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.