

FURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

FILED VS NOV 16 1959

59-042971

STATE FILE NUMBER

Registration District No. 319 Primary Registration District No. _____ Registrar's No. 64

DOCUMENT
 MEDICAL CERTIFICATION
 BY AFFIDAVIT OF

1. PLACE OF DEATH a. COUNTY <u>ST. GENEVIEVE</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MO</u> b. COUNTY <u>ST. GEN.</u>			
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>BLOOMSDALE</u>		Length of stay in 1b <u>5 YRS</u>		c. CITY OR TOWN <u>BLOOMSDALE</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>3 mi W. OF BLOOMSDALE</u>				H.Y.E. Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location) <u>RT. 1. ON H.Y.E.</u>	
3. NAME OF DECEASED (Type or print) First <u>LOTTIE</u> Middle <u>T</u> Last <u>THRELKELD</u>				4. DATE OF DEATH Month <u>NOV.</u> Day <u>10</u> Year <u>1959</u>			
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</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>DEC. 8, 1884</u>	9. AGE (last birthday) <u>65</u>	IF UNDER 1 YEAR Months _____ Days _____	IF UNDER 24 HR Hours _____ Min. _____	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>AT HOME</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>—</u>		11. BIRTHPLACE (City and state or country) <u>JOPLIN MO.</u>		12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>	
13a. FATHER'S NAME <u>JAMES LAMB</u>			13b. MOTHER'S MAIDEN NAME <u>EMMA PERKINS</u>			14. NAME OF HUSBAND OR WIFE <u>ISAAC N. THRELKELD</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>494-26-3280</u>		17. INFORMANT Address <u>MRS. ANITA WERNER BLOOMSDALE 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>CARD. AC DECOMPENSATION, Acute</u> INTERVAL BETWEEN ONSET AND DEATH <u>1 W</u>							
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <u>CHRONIC ARTERIAL FIBRILLATION</u> <u>4 YEARS</u>							
DUE TO (c) <u>ARTERIOSCLEROTIC HEART DISEASE</u> <u>10 YEARS</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 _____ 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 <u>7-12-55</u> to <u>11-10-59</u> and last saw her ^{her} _{him} live on <u>10-19-59</u> Death occurred at <u>7 P.M.</u> on the date stated above, and to the best of my knowledge, from the causes stated.							
22a. SIGNATURE (Degree or title) <u>[Signature]</u>				22b. ADDRESS <u>[Address]</u>		22c. DATE SIGNED <u>11-11-59</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE <u>NOV. 6 1959</u>		23c. NAME OF CEMETERY OR CREMATORY <u>WOODLAWN PARK</u>		23d. LOCATION (City, town, or county) <u>DeSOTO MO.</u>	
24. FUNERAL DIRECTOR ADDRESS <u>DIETRICH F. HOME DeSOTO MO.</u>				25. DATE RECD. BY LOCAL REG. <u>11/11/59</u>		26. REGISTRAR'S SIGNATURE <u>[Signature]</u>	

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 Donald B. Dietrich

Licensed Embalmer No. 4104

P. O. Address Delaware 160

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.