

RI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

59-043057

FILED VS NOV 18 1959

STATE FILE NUMBER

Registration District No. 340 Primary Registration District No. 3075 Registrar's No. 102

INDEXED

1. PLACE OF DEATH		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)	
a. COUNTY <u>STODDARD</u>	b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>DEXTER</u>	a. STATE <u>MISSOURI</u>	b. COUNTY <u>SCOTT</u>
Length of stay in 1b <u>2 1/2 MONS.</u>		c. CITY OR TOWN <u>ORAN</u>	Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (IF NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>GREEN MEADOWS REST HOME</u>		d. STREET ADDRESS (If outside, give location)	Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print)			4. DATE OF DEATH	
First <u>MARY</u>	Middle <u>EFFIE</u>	Last <u>ESTES</u>	Month <u>NOV.</u>	Day <u>6</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>3/4/1881</u>	9. AGE (last birthday) <u>78</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>HOME</u>	11. BIRTHPLACE (City and state or country) <u>MILLERSVILLE, MO.</u>	12. CITIZEN OF WHAT COUNTRY <u>U. S. A.</u>
13a. FATHER'S NAME <u>JAMES ELLISON HUTTON</u>		13b. MOTHER'S MAIDEN NAME <u>MISSOURI E. ESTES</u>		14. NAME OF HUSBAND OR WIFE <u>EARL L. ESTES</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 <u>EARL L. ESTES</u> Address <u>ORAN, MO.</u>	

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)		INTERVAL BETWEEN ONSET AND DEATH <u>1 year</u>
PART I. DEATH WAS CAUSED BY:		
IMMEDIATE CAUSE (a) <u>Cardio-Renal Vascular Disease</u>	DUE TO (b) <u>~</u>	
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (c) <u>~</u>	

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>~</u>	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
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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>~</u>
20c. TIME OF INJURY Hour a.m. p.m.	Month, Day, Year <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.) <u>~</u>	20f. CITY, TOWN, OR LOCATION <u>~</u>
		COUNTY <u>~</u>
		STATE <u>~</u>

21. I attended the deceased from March 13-14 to NOV. 6, 1959 and last saw him alive on May, 1959
Death occurred at 7:15 a.m. on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE <u>[Signature]</u>	(Degree or title) <u>MD</u>	22b. ADDRESS <u>234N Sprigg Cape Girardeau</u>	22c. DATE SIGNED <u>11-7-59</u>
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	23b. DATE <u>NOV. 8, 1959</u>	23c. NAME OF CEMETERY OR CREMATORY <u>FRIEND CEMETERY</u>	23d. LOCATION (City, town, or county) <u>ORAN SCOTT MO.</u>

24. FUNERAL DIRECTOR <u>[Signature]</u>	ADDRESS <u>ORAN, MO.</u>	25. DATE RECD. BY LOCAL REG.	26. REGISTRAR'S SIGNATURE <u>[Signature]</u>
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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 *Earl J. Smith*

Licensed Embalmer No. 2676

P. O. Address Orem, 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.