

BUREAU OF HEALTH - STANDARD CERTIFICATE OF DEATH

59-043200

STATE FILE NUMBER

FILED VS NOV 20 1959

Registration District No. 375 Primary Registration District No. 6288 Registrar's No. 31

ENDED

1. PLACE OF DEATH a. COUNTY <u>Wright</u> b. CITY (if outside corporate limits, give TOWNSHIP only) OR TOWN <u>Grove Springs</u> Length of stay in 1b <u>60 years</u> c. FULL NAME OF (IF NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>Home-Grove Spr</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>MO.</u> b. COUNTY <u>Wright</u> c. CITY OR TOWN <u>Grove Springs</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> d. STREET ADDRESS (If outside, give location) <u>East Part-Grove Springs</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>Mary</u> Middle <u>MOLLIE</u> Last <u>GORDON</u>			4. DATE OF DEATH Month <u>11</u> Day <u>8</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>11-12-1869</u>	9. AGE (last birthday) <u>89</u>	IF UNDER 1 YEAR Months <u>11</u> Days <u>27</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		11. BIRTHPLACE (City and state or country) <u>Grove Springs, MO.</u>		12. CITIZEN OF WHAT COUNTRY <u>U. S. A.</u>

13a. FATHER'S NAME <u>Gaberial Davis</u>	13b. MOTHER'S MAIDEN NAME	14. NAME OF HUSBAND OR WIFE <u>Dwaine Pearson</u> Address <u>Grove Springs MO.</u>
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.
17. INFORMANT <u>Dwaine Pearson</u> Address <u>Grove Springs 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>INANITION + DEBILITATION</u> DUE TO (b) <u>CARCINOMATOSIS</u> DUE TO (c) <u>PRIMARY CANCER OF CERVIX UTERIS</u> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.		INTERVAL BETWEEN ONSET AND DEATH
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>3-9-59</u> to <u>11-8-59</u> and last saw her <u>alive</u> on <u>11-3-59</u> Death occurred at _____ m on the date stated above, and to the best of my knowledge, from the causes stated.			

22a. SIGNATURE 	(Degree or title) <u>Dr.</u>	22b. ADDRESS <u>Manassas, Va.</u>	22c. DATE SIGNED <u>11/13/59</u>
23. BURIAL - CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE <u>11-11-1959</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Davis Cemetery</u>	23d. LOCATION (City, town, or county) <u>Wright Co.</u> (State) <u>MO</u>
24. FUNERAL DIRECTOR <u>John Simpson</u> ADDRESS <u>HARTVILLE, MO.</u>		25. DATE RECD. BY LOCAL REG. <u>11-17-59</u>	26. REGISTRAR'S SIGNATURE

(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 Wm. C. Simpson

Licensed Embalmer No. 5071

P. O. Address _____

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.