

URI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

FILED VS DEC 22 1959

59 0 4 4 6 2 3

ENDED

Registration District No. 171 Primary Registration District No. 8438 Registrar's No. 58

STATE FILE NUMBER

1. PLACE OF DEATH a. COUNTY <u>Jackson Lafayette</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Mo</u> b. COUNTY <u>Lafayette</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Bates City (Smaller)</u>		c. CITY OR TOWN <u>Bates City</u>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>2 mi South</u>		d. STREET ADDRESS (If outside, give location) <u>2 mi South</u>	

3. NAME OF DECEASED (Type or print) First Middle Last <u>Sally C Bainbridge</u>		4. DATE OF DEATH Month Day Year <u>Dec 15th 1959</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>Wh</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>12-30-1869</u>
9. AGE (last birthday) <u>90</u>		IF UNDER 1 YEAR IF UNDER 24 HR Months Days Hours Min.	

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired house wife</u>	10b. KIND OF BUSINESS OR INDUSTRY <u>Smithville Mo</u>	11. BIRTHPLACE (City and state or country) <u>USA</u>	12. CITIZEN OF WHAT COUNTRY <u>USA</u>
--	---	--	---

13a. FATHER'S NAME <u>John Robertson</u>	13b. MOTHER'S MAIDEN NAME <u>Hanna Byrd</u>	14. NAME OF HUSBAND OR WIFE <u>Deceased</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>Grace Scott Oak Grove 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>Arterio Sclerosis Heart Disease</u>		INTERVAL BETWEEN ONSET AND DEATH <u>3 years</u>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <u>—</u> 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>Senility</u>		PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown
--	--	---

19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input 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. <u>—</u>	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 <u>5-6-58</u> to <u>12-11-59</u> and last saw her alive on <u>12-8-59</u>	
Death occurred at <u>8:00</u> A m on the date stated above, and to the best of my knowledge, from the causes stated.	

22a. SIGNATURE <u>John W. Williams MD</u>	22b. ADDRESS <u>Oak Grove, Mo</u>	22c. DATE SIGNED <u>12-11-59</u>
--	--------------------------------------	-------------------------------------

23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Buried</u>	23b. DATE <u>12-18-1969</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Bates City Cem</u>	23d. LOCATION (City, town, or county) (State) <u>Bates City Mo</u>
--	--------------------------------	---	---

24. FUNERAL DIRECTOR <u>Walt Funeral Home Oak Grove Mo</u>	25. DATE RECD. BY LOCAL REG. <u>12-15-1959</u>	26. REGISTRAR'S SIGNATURE <u>Emma Davidson</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 R B Webb

Licensed Embalmer No. 2357

P. O. Address Blue Springs

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.