

FILED VS DEC 29 1959

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

'59 0 4 4 7 7 8  
STATE FILE NUMBER

Registration District No. 210 Primary Registration District No. \_\_\_\_\_ Registrar's No. 67

V. S. 300  
Rev. 1-57

1. PLACE OF DEATH a. COUNTY <b>Mercer</b>			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Mo.</b> b. COUNTY <b>Mercer</b>		
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>Marian Twp.</b>		Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	c. CITY OR TOWN <b>Mercer</b>		Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>Own Home</b>		Length of stay in 1b <b>10 yrs.</b>	d. STREET ADDRESS (If outside, give location)		Reside on Farm Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <b>Rachael</b> Middle <b>Ann</b> Last <b>Gloshen</b>			4. DATE OF DEATH Month <b>Nov.</b> Day <b>28,</b> Year <b>1959</b>		
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>March 28, 1885</b>	9. AGE (In years last birthday) <b>74</b>	IF UNDER 1 YEAR Months _____ Days _____ IF UNDER 24 HRS. Hours _____ Min. _____
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Own Home</b>	11. BIRTHPLACE (City and state or country) <b>Iowa</b>	12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13a. FATHER'S NAME <b>Andrew King</b>		13b. MOTHER'S MAIDEN NAME <b>Sarah Crawford</b>		14. NAME OF HUSBAND OR WIFE <b>Everett Gloshen</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>	17. INFORMANT <b>Neo K. Gloshen</b> Address <b>306 W 54th St, Mill Kansas City, Mo.</b>		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Congestive Circulatory Failure</b>					INTERVAL BETWEEN ONSET AND DEATH <b>8 hours</b>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. } DUE TO (b) <b>Decompensated heart disease</b>					<b>6 weeks</b>
DUE TO (c) <b>Arteriosclerosis</b> <b>4500</b>					<b>years</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)					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 <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 <b>Sept. 1959</b> to <b>Nov. 28, 1959</b> last saw her/him alive on <b>Nov. 28, 1959</b> Death occurred at <b>9:45 PM</b> m on the date stated above; and to the best of my knowledge, from the causes stated.					
22a. SIGNATURE <b>Geo J. Lawson M.D.</b> (Degree or title) <b>2</b>			22b. ADDRESS <b>Mercer, Missouri</b>		22c. DATE SIGNED <b>12/12/59</b>
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE <b>Dec. 1, 1959</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Middlepoint Cemetery</b>		23d. LOCATION (City, town, or county) (State) <b>Mercer County Mo.</b>	
24. FUNERAL DIRECTOR <b>James Spaulding</b> ADDRESS <b>Lineville Iowa</b>		25. DATE RECD. BY LOCAL REG. <b>12-12-59</b>	26. REGISTRAR'S SIGNATURE <b>Paul M. [Signature]</b>		

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

securing the medical certification in the specific manner required by 193.140 MoRS 1949. Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed. All diseases in Part I must be causally related.

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, ~~only~~ ....., Student Embalmer No. .... working under my personal supervision.

Student .....  
Signature of Student Embalmer

Signed *James L. Greenlee*

Licensed Embalmer No. *3967*

P. O. Address *Linnville, La*

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.