

FURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

'59 0 45 1 20

FILED VS. DEC 17 1959

STATE FILE NUMBER

Registration District No. 201 Primary Registration District No. _____ Registrar's No. 72

RECEIVED

1. PLACE OF DEATH a. COUNTY <u>Ripley</u> b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Naylor</u> Length of stay in lb <u>Years</u> c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>1 block N. FRONT ST.</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>Missouri</u> b. COUNTY <u>Ripley</u> c. CITY OR TOWN <u>Naylor</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> d. STREET ADDRESS (If outside, give location) <u>Gen. Delivery</u> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>ALMA</u> Middle <u>VIRGIE</u> Last <u>RISENHOOVER</u>			4. DATE OF DEATH Month <u>NOVEMBER</u> Day <u>14</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>4-4-1890</u>	9. AGE (last birthday) <u>69</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>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>at Home</u>		11. BIRTHPLACE (City and state or country) <u>Ripley Co. - Missouri</u>	12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>
13a. FATHER'S NAME <u>ANDREW RANDEL</u>		13b. MOTHER'S MAIDEN NAME <u>ABBIE LOGAN</u>		14. NAME OF HUSBAND OR WIFE <u>T.A. RISENHOOVER</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>T.A. RISENHOOVER - NAYLOR - Mo.</u> Address		
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>Cerebral Hemorrhage</u> DUE TO (b) <u>Cerebral Arteriosclerosis</u> DUE TO (c) _____ Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.					INTERVAL BETWEEN ONSET AND DEATH <u>30 minutes</u> <u>Years</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>Menieres Disease (5 years duration)</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 checked="" type="checkbox"/>	20a. ACCIDENT SUICIDE HOMICIDE <input type="checkbox"/> <input type="checkbox"/> <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>March 19, 1954</u> to <u>Nov. 14, 1959</u> and last saw her <u>alive</u> on <u>Nov. 14, 1959</u> Death occurred at <u>10:30</u> p.m. on the date stated above, and to the best of my knowledge, from the causes stated.					
22a. SIGNATURE <u>J. L. Smith, D.O.</u> (Degree or title)			22b. ADDRESS <u>Naylor, Mo.</u>		22c. DATE SIGNED <u>12-1-59</u>
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE <u>11-16-1959</u>	23c. NAME OF CEMETERY OR CREMATORY <u>MASONIC Cemetery</u>		23d. LOCATION (City, town, or county) (State) <u>NAYLOR - MISSOURI</u>	
24. FUNERAL DIRECTOR <u>Gene Parrent - NAYLOR - Mo.</u> ADDRESS		25. DATE RECD. BY LOCAL REG. <u>Dec. 10 - 1959</u>	26. REGISTRAR'S SIGNATURE <u>Flava Broz</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 Gene H. Parent

Licensed Embalmer No. 4809

P. O. Address Naylor 7

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.