

# MURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

FILED VS DEC 22 1959

59 045155  
STATE FILE NUMBER

Registration District No. 316 Primary Registration District No. 3059 Registrar's No. 476

ENDED

1. PLACE OF DEATH a. COUNTY <b>St. Francois.</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Mo.</b> b. COUNTY <b>St. Francois</b>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>Bonne Terre</b>		Length of stay in 1b <b>**</b>	c. CITY OR TOWN <b>Bonne Terre</b> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>Bonne Terre Hospital</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <b>125 Middle St.</b> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print) <b>* ELLEN MARIE WHITE *</b>			4. DATE OF DEATH <b>Dec. 13, 1959</b>		
First		Middle		Last	

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>12-27-1899</b>	9. AGE (last birthday) <b>59</b>	IF UNDER 1 YEAR Months	IF UNDER 24 HR Days	Hours	Min.
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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>**</b>	11. BIRTHPLACE (City and state or country) <b>Ste. Genevieve Mo.</b>	12. CITIZEN OF WHAT COUNTRY <b>USA</b>
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13a. FATHER'S NAME <b>John Gifford</b>	13b. MOTHER'S MAIDEN NAME <b>Emma Mc Daniel</b>	14. NAME OF HUSBAND OR WIFE <b>Earl J. White</b>
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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>**</b>	17. INFORMANT <b>Earl J. White</b>	Address <b>Bonne Terre, Mo.</b>
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18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY:		INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a) <b>Coronary thrombosis with myocardial infarction - 12 hrs.</b>		
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b)	
	DUE TO (c)	

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <b>Diabetes mellitus - several years.</b>	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.)
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20c. TIME OF INJURY Hour a.m. p.m.	Month, Day, Year
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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
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21. I attended the deceased from Dec. 1956 to Dec. 13, 1959 and last saw her <sup>her</sup> alive on Dec. 13, 1959  
Death occurred at 2:30 <sup>P</sup>m on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE <b>Martin J. Haw, J., M.D.</b> (Degree or title)	22b. ADDRESS <b>Bonne Terre, Mo.</b>	22c. DATE SIGNED <b>12/14/59</b>
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23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE <b>Dec. 16, 1959</b>	23c. NAME OF CEMETERY OR CREMATORY <b>St. Fran. Mem. Park.</b>	23d. LOCATION (City, town, or county) (State) <b>Bonne Terre, Mo.</b>
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24. FUNERAL DIRECTOR <b>CZ BOYER &amp; SON INC</b>	ADDRESS <b>Bonne Terre Mo</b>	25. DATE RECD. BY LOCAL REG. <b>Dec. 15, 1959</b>	26. REGISTRAR'S SIGNATURE <b>Cather Rudloff</b>
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(Licensed Embalmer's Statement on Reverse Side)

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

CP. + 1/10/10

**STATEMENT BY LICENSED EMBALMER**

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by \_\_\_\_\_  
or by \_\_\_\_\_, Student Embalmer No. \_\_\_\_\_  
working under my personal supervision.

Student \_\_\_\_\_  
Signature of Student Embalmer

Signed B. T. Boyer  
B.. T.. Boyer

Licensed Embalmer No. 3660

P. O. Address Desloge, 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.