

URI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

FILED VS DEC 28 1959 316

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STATE FILE NUMBER

Registration District No. _____ Primary Registration District No. _____ Registrar's No. 493

1. PLACE OF DEATH a. COUNTY <u>ST. FRANCIS</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before a. STATE <u>MO</u> b. COUNTY <u>ST. FRANCIS</u>)									
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>DESLOGE, MO.</u>		Length of stay in 1b		c. CITY OR TOWN <u>DESLOGE, MO.</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>							
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION			Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location) <u>MONROE</u>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>						
3. NAME OF DECEASED (Type or print) First <u>CECIL</u> Middle <u>B.</u> Last <u>DEES</u>				4. DATE OF DEATH Month <u>Dec.</u> Day <u>22</u> Year <u>1959</u>									
5. SEX <u>MALE</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>9-14-1898</u>		9. AGE (last birthday) <u>61</u>		IF UNDER 1 YEAR Months _____ Days _____		IF UNDER 24 HR Hours _____ Min. _____	
10a. USUAL OCCUPATION (Give kind of work done during most of year, even if retired) <u>LABOR</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>LABOR</u>		11. BIRTHPLACE (City and state or country) <u>DOE RUN, MO</u>		12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>					
13a. FATHER'S NAME <u>THOMAS DEES</u>				13b. MOTHER'S MAIDEN NAME <u>JANE SMITH</u>				14. NAME OF HUSBAND OR WIFE <u>GLENDA DEES</u>					
15. HAS DECEASED EVER IN U.S. ARMED FORCES? <u>YES WWI 1912-14</u>				16. SOCIAL SECURITY NO.		17. INFORMANT <u>MRS. GLENDA DEES DESLOGE</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>CORONARY THROMBOSIS</u>										INTERVAL BETWEEN ONSET AND DEATH <u>1 Hour</u>			
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)								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 _____ 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>12-29-59</u> to <u>12-29-59</u> and last saw <u>him</u> alive on <u>NEVER</u> Death occurred at <u>1:30 PM</u> m on the date stated above, and to the best of my knowledge, from the causes stated.													
22a. SIGNATURE (Degree or title) <u>C. E. Howell, D.O.</u>				22b. ADDRESS <u>Flat River, Mo.</u>				22c. DATE SIGNED <u>12-23-59</u>					
23a. BURIAL, CREMATION, OR OTHER DISPOSITION (Specify) <u>BURIAL</u>		23b. DATE <u>DEC 29, 1959</u>		23c. NAME OF CEMETERY OR CREMATORY <u>ST. FRANCIS MEM. PARK NEAR BONNE TERRE, MO.</u>		23d. LOCATION (City, town, or county) (State)							
24. FUNERAL DIRECTOR <u>R. CALDWELL & SONS FLAT RIVER, MO</u> ADDRESS _____				25. DATE RECD. BY LOCAL REG. <u>Dec. 23, 1959</u>		26. REGISTRAR'S SIGNATURE <u>Cather Rudloff</u>							

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 Donald Dale Caldwell, Student Embalmer No. 587

working under my personal supervision.

Student Donald Dale Caldwell Signed R. Caldwell
Signature of Student Embalmer

Licensed Embalmer No. 2531

P. O. Address Flat River

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.