

RI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

FILED VS. DEC 29 1959 73

Primary Registration District No. 6267-375

Registrar's No. 53

'59 046625 STATE FILE NUMBER

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|--|--|--|--|--|---|
| 1. PLACE OF DEATH a. COUNTY WEBSTER | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MO b. COUNTY WEBSTER | | |
| b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN ELKLAND MO | | Length of stay in 1b 35 YRS | c. CITY OR TOWN ELKLAND MO | | 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) | |
| 3. NAME OF DECEASED (Type or print) ASENATH MCNABB | | | First | Middle | Last |
| | | | 4. DATE OF DEATH DEC 12 1959 | Month | Day |
| 5. SEX FEMALE | 6. COLOR OR RACE WHITE | 7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/> | 8. DATE OF BIRTH 12-9-1870 | 9. AGE (last birthday) 89 | IF UNDER 1 YEAR Months Days |
| | | | | | IF UNDER 24 HR Hours Min. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE | | 10b. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (City and state or country) Missouri | 12. CITIZEN OF WHAT COUNTRY U.S.A |
| 13a. FATHER'S NAME JAMES GODDSON | | | 13b. MOTHER'S MAIDEN NAME MIRIAM TROTTER | | 14. NAME OF HUSBAND OR WIFE |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) NO | | | 16. SOCIAL SECURITY NO. | 17. INFORMANT Address JOYCE PRICE MARSHFIELD MO | |
| 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) Coronary Artery Occlusion, Acute | | | | | 30 min. |
| Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) Cardio-Vascular Disease | | | | | 15 yrs. |
| DUE TO (c) Arteriosclerosis, Generalized | | | | | More Than 15 years. |
| 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 checked="" 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 Month, Day, Year a.m. p.m. | | | | | |
| 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 about 1930 to Nov. 10, 1959 and last saw her ^{her} _{him} alive on Nov. 10, 1959 Death occurred at 630 A.m on the date stated above, and to the best of my knowledge, from the causes stated. | | | | | |
| 22a. SIGNATURE (Degree or title) C. Macdonnell, M.D. | | | 22b. ADDRESS Marshfield, Mo. | | 22c. DATE SIGNED 12-12-59 |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL | 23b. DATE 12-14-1959 | 23c. NAME OF CEMETERY OR CREMATORY PLEASANT VIEW | | 23d. LOCATION (City, town, or county) (State) WEBSTER CO MO | |
| 24. FUNERAL DIRECTOR ADDRESS BARBER-EDWARDS MARSHFIELD | | | 25. DATE RECD. BY LOCAL REG. 12-21-59 | 26. REGISTRAR'S SIGNATURE J. Francis | |

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

or by _____, Student Embalmer No. _____

working under my personal supervision.

Student _____

Signature of Student Embalmer

Signed



Licensed Embalmer No. 380

P. O. Address W. B. Stone

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to conform 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.