

RI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-60-014037

FILED 15 APR 25 1960

STATE FILE NUMBER

Registration District No. 1 Primary Registration District No. 3000 Registrar's No. 107

1. PLACE OF DEATH a. COUNTY <u>Adair</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MO.</u> b. COUNTY <u>Adair</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Kirksville</u>		c. CITY OR TOWN <u>Kirksville</u>	
Length of stay in 1b		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (IF NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>Grim-Smith Hospital</u>		d. STREET ADDRESS (If outside, give location) <u>1601 E. Normal</u>	
Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	

3. NAME OF DECEASED (Type or print) <u>Addie</u>	First	Middle	Last	4. DATE OF DEATH Month <u>April</u> Day <u>18</u> Year <u>1960</u>
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5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <u>11/15/1874</u>	9. AGE (last birthday) <u>85</u>	IF UNDER 1 YEAR Months	IF UNDER 24 HR Days	IF UNDER 24 HR Hours	IF UNDER 24 HR Min.
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Home</u>	10b. KIND OF BUSINESS OR INDUSTRY <u>Home</u>	11. BIRTHPLACE (City and state or country) <u>Apponoose County, Iowa</u>	12. CITIZEN OF WHAT COUNTRY <u>U. S. A.</u>
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13a. FATHER'S NAME <u>Samuel A. Ulrich</u>	13b. MOTHER'S MAIDEN NAME <u>Mary Cooksey</u>	14. NAME OF HUSBAND OR WIFE <u>Henry Hudson</u>
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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) <u>No</u>	16. SOCIAL SECURITY NO. <u>None</u>	17. INFORMANT Address <u>Henry Hudson, Bloomfield, Iowa</u>
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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) <u>Uremia</u>		<u>6 wks</u>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) <u>Arteriosclerotic Heart Disease</u>	<u>10 yrs</u>
	DUE TO (c) <u>Heart Block</u>	<u>6 wks</u>

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
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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.) <u>—</u>
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20c. TIME OF INJURY Hour <u>—</u> a.m. <u>—</u> p.m. <u>—</u>	Month, Day, Year <u>—</u>
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20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <u>—</u>	20f. CITY, TOWN, OR LOCATION <u>—</u> COUNTY <u>—</u> STATE <u>—</u>
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21. I attended the deceased from Sept 1947 to June 18, 1960 and last saw her alive on June 18, 1960  
Death occurred at 10:20 A m on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE <u>Melton T. Eberlein MA</u>	(Degree or title)	22b. ADDRESS <u>Kirksville, Mo.</u>	22c. DATE SIGNED <u>4-19-60</u>
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23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE <u>4/20/1960</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Highland Park Cemetery</u>	23d. LOCATION (City, town, or county) (State) <u>Kirksville, Mo.</u>
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24. FUNERAL DIRECTOR <u>Paul M. Riley</u>	ADDRESS <u>Kirksville, Mo.</u>	25. DATE RECD. BY LOCAL REG. <u>4-22-1960</u>	26. REGISTRAR'S SIGNATURE <u>Doris W. Gatliff</u>
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DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

WILSON T. ENGLISH, M.D.

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 George W. Davel

Licensed Embalmer No. 4799

P. O. Address Huberville

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.