

IRI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-60-014394

FILED VS MAY 5 1960 43

240

STATE FILE NUMBER

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

DEED

1. PLACE OF DEATH a. COUNTY <u>Butler</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence <input checked="" type="checkbox"/> Fore admission) a. STATE <u>Mo.</u> b. COUNTY <u>Butler</u>	
b. CITY (if outside corporate limits, give TOWNSHIP only) OR TOWN <u>Paplar Bluff</u>		Length of stay in lb <u>14 months</u>	c. CITY OR TOWN <u>Paplar Bluff</u> Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
c. FULL NAME OF (if NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>Home</u>		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <u>R-5</u> Reside on Farm Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>

3. NAME OF DECEASED (Type or print) First <u>Clara</u> Middle <u>Elledge</u> Last <u>Elledge</u>			4. DATE OF DEATH Month <u>4</u> Day <u>12</u> Year <u>1960</u>			
---	--	--	---	--	--	--

5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</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>9-3-1875</u>	9. AGE (last birthday) <u>85</u>	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) <u>Housewife</u>	10b. KIND OF BUSINESS OR INDUSTRY _____	11. BIRTHPLACE (City and state or country) <u>Iowa</u>	12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>
--	---	--	---

13a. FATHER'S NAME <u>John R. Stewart</u>		13b. MOTHER'S MAIDEN NAME <u>Mary Ellen Riker</u>		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) <u>no</u>		16. SOCIAL SECURITY NO. <u>none</u>	17. INFORMANT <u>Edward Elledge - Paplar Bluff, Mo</u> Address <u>R-5</u>
--	--	-------------------------------------	---

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 <u>10 years</u> <u>20 years</u>
IMMEDIATE CAUSE (a) <u>Chronic Myocarditis</u>			
DUE TO (b) <u>Arteriosclerosis</u>			
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.		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 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 2-5-1959 to 12 April 60 and last saw her alive on 11 April 60
 Death occurred at 3:30 P.M. on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) <u>Chas. A. Post M.D.</u>	22b. ADDRESS <u>Paplar Bluff, Mo.</u>	22c. DATE SIGNED <u>15 April 60</u>
--	---------------------------------------	-------------------------------------

23. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE <u>4-14-1960</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Norfolk Cemetery</u>	23d. LOCATION (City, town, or county) (State) <u>Norfolk, Arkansas</u>
--	----------------------------	--	--

24. FUNERAL DIRECTOR <u>Home Improvement</u> ADDRESS _____	25. DATE RECD BY LOCAL REG. <u>4/20/60</u>	26. REGISTRAR'S SIGNATURE <u>R. Mueller</u>
--	--	---

DOCUMENT

MEDICAL CERTIFICATION

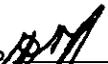
BY AFFIDAVIT OF

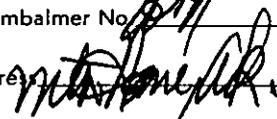
STATEMENT BY LICENSED EMBALMER

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

Student _____
Signature of Student Embalmer

Signed 

Licensed Embalmer No. 

P. O. Address 

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.