

**JURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH**

**-60-019193**

**FILED VS MAY 24 1960**

Registration District No. 140 Primary Registration District No. 3024 Registrar's No. 54

STATE FILE NUMBER

1. PLACE OF DEATH a. COUNTY <b>Howard</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Missouri</b> COUNTY <b>Howard</b>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>Fayette, Mo.</b>		Length of stay in 1b <b>12 days</b>	c. CITY OR TOWN <b>Fayette,</b> Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>Lee Hospital</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <b>Richmond Twp.</b> Reside on Farm Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>

3. NAME OF DECEASED (Type or print) First <b>STELLA</b> Middle <b>AUSTIN</b> Last <b>BESGROVE</b>			4. DATE OF DEATH Month <b>MAY</b> Day <b>15</b> Year <b>1960</b>			
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5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <b>11/9/1874</b>	9. AGE (last birthday) <b>85</b>	IF UNDER 1 YEAR Months _____ Days _____	IF UNDER 24 HR 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>Own Home</b>	11. BIRTHPLACE (City and state or country) <b>Howard County, Mo.</b>	12. CITIZEN OF WHAT COUNTRY <b>U.S.A.</b>
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13a. FATHER'S NAME <b>Austin Jones</b>	13b. MOTHER'S MAIDEN NAME <b>Kate Mariah Hancock</b>	14. NAME OF HUSBAND OR WIFE <b>William Alfred Besgrove</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>None</b>	17. INFORMANT <b>Mrs L. E. Zeigler Dpwmers Grove Ill.</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>(1) Coronary Thrombosis</b>		<b>3 days</b>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) <b>(3) Fracture of Hip</b>	<b>8-10 hrs</b>
	DUE TO (c) <b>(2) Chronic Arteriosclerosis</b>	<b>5 yrs</b>

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
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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 10-23-60 to 5-15-60 and last saw her alive on 5-15-60.  
Death occurred at 10 am on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Deceased or title) <b>W. Bloom Jr.</b>	22b. ADDRESS <b>Fayette Mo</b>	22c. DATE SIGNED <b>5-19-60</b>
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23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE <b>5/18/1960</b>	23c. NAME OF CEMETERY OR CREMATORY <b>City Cemetery</b>	23d. LOCATION (City, town, or county) (State) <b>Fayette, Missouri</b>
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24. GENERAL DIRECTOR <b>Felph A. Carr</b>	ADDRESS <b>Fayette, Mo.</b>	25. DATE RECD. BY LOCAL REG. <b>5-19-60</b>	26. REGISTRAR'S SIGNATURE <b>Katherine Welch</b>
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(Licensed Embalmer's Statement on Reverse Side)

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 Ralph A. Cass

Licensed Embalmer No. 334

P. O. Address Fayette

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.