

IRI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-60-023946

FILED VS. JUN 20 1960

251

Primary Registration District No. \_\_\_\_\_

Registrar's No. 149

STATE FILE NUMBER

|   |  |   |  |   |  |  |   |  |   |   |  |  |  |
|---|--|---|--|---|--|--|---|--|---|---|--|--|--|
| 1. PLACE OF DEATH<br>a. COUNTY <u>Nodaway</u>   |  |   |  | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <u>Missouri</u> b. COUNTY <u>Nodaway</u>                  |  |  |   |  |   |   |  |  |  |
| b. CITY (If outside corporate limits, give TOWNSHIP only)<br>OR<br>TOWN <u>Polk Township</u>  |  | Length of stay in lb<br><u>4 days</u>   |  | c. CITY OR TOWN <u>Skidmore</u>   |  | Inside Limits<br>Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> |   |  |   |   |  |  |  |
| c. FULL NAME OF (If NOT in hospital, give location)<br>HOSPITAL OR INSTITUTION <u>Nodaway Rest Home</u>   |  |   | Inside Limits<br>Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>     |   | d. STREET ADDRESS (If outside, give location)<br><u>none</u> |  | Reside on Farm<br>Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> |  |   |   |  |  |  |
| 3. NAME OF DECEASED (Type or print)<br>First <u>CELIA</u> Middle <u>M.</u> Last <u>LINVILLE</u>   |  |   |  | 4. DATE OF DEATH<br>Month <u>6</u> Day <u>9</u> Year <u>60</u>  |  |  |   |  |   |   |  |  |  |
| 5. SEX<br><u>Female</u>   |  | 6. COLOR OR RACE<br><u>White</u>  |  | 7. Married <input type="checkbox"/> Never Married <input type="checkbox"/><br>Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/> |  | 8. DATE OF BIRTH<br><u>11/30/71</u>  |   | 9. AGE (last birthday) <u>88</u>                               |   | IF UNDER 1 YEAR<br>Months _____ Days _____  |  | IF UNDER 24 HR<br>Hours _____ Min. _____ |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><u>Housewife</u>   |  |   |  | 10b. KIND OF BUSINESS OR INDUSTRY<br><u>Own home</u>  |  | 11. BIRTHPLACE (City and state or country)<br><u>Siam, Iowa</u>                      |   | 12. CITIZEN OF WHAT COUNTRY<br><u>USA</u>                      |   |   |  |  |  |
| 13a. FATHER'S NAME<br><u>Chester Rees</u>   |  |   |  | 13b. MOTHER'S MAIDEN NAME<br><u>Rachael</u>   |  |  |   | 14. NAME OF HUSBAND OR WIFE<br><u>dec. William S. Linville</u> |   |   |  |  |  |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)<br><u>no</u>   |  |   |  | 16. SOCIAL SECURITY NO.<br><u>none</u>  |  | 17. INFORMANT<br>Address<br><u>Everett Linville, Skidmore, Mo.</u>                   |   |  |   |   |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Cerebro-vascular thrombosis</u><br>DUE TO (b) <u>Cerebral arteriosclerosis</u><br>DUE TO (c) _____<br>Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. |  |   |  |   |  |  |   |  |   | INTERVAL BETWEEN ONSET AND DEATH<br><u>30 min.</u>  |  |  |  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)<br><u>arteriosclerotic heart disease</u>  |  |   |  |   |  |  |   |  |   | PART III. If deceased was female was there a pregnancy in last 90 days.<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown |  |  |  |
| 19. WAS AUTOPSY PERFORMED?<br>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<br>Hour _____ s.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>11/14/57</u> to <u>6/9/60</u> and last saw her alive on <u>6/6/60</u><br>Death occurred at <u>3:15</u> p. m. on the date stated above, and to the best of my knowledge, from the causes stated.   |  |   |  |   |  |  |   |  |   |   |  |  |  |
| 22a. SIGNATURE<br><u>B. F. Byland</u> (Degree or title) <u>M.D.</u>   |  |   |  |   |  | 22b. ADDRESS<br><u>Marville, Missouri</u>  |   |  | 22c. DATE SIGNED<br><u>6/11/60</u>            |   |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><u>burial</u>  |  | 23b. DATE<br><u>6/11/60</u>   |  | 23c. NAME OF CEMETERY OR CREMATORY<br><u>Hillcrest</u>  |  | 23d. LOCATION (City, town, or county)<br><u>Skidmore, Missouri</u>                   |   | (State)  |   |   |  |  |  |
| 24. FUNERAL DIRECTOR<br><u>Price Funeral Home, Marville, Mo.</u>  |  |   |  |   | ADDRESS  |  | 25. DATE RECD. BY LOCAL REG.<br><u>6-11-60</u>  |  | 26. REGISTRAR'S SIGNATURE<br><u>Beas Holt</u> |   |  |  |  |

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

JUL 20 1960

**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 Chas M. Price

Licensed Embalmer No. 1822

P. O. Address Maryville

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.