RI DIVISION OF HEALTH — STANDARD CERTIFICATE OF DEATH

-60-024449

STATE FILE NUMBER

ED VS JUL 12 1960 Registration District No. 318 1003 Primary Registration District No. _____ Registrar's No. 6364

1. PLACE OF DEATH
a. COUNTY
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN: ST. LOUIS, MISSOURI
Length of stay in 1b
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION: BARNES HOSPITAL
Inside Limits: Yes ☐ No ☐

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Arkansas
b. COUNTY: Randolph
c. CITY OR TOWN: Maynard
Inside Limits: Yes ☒ No ☐
d. STREET ADDRESS (If outside, give location): Route #1
Reside on Farm: Yes ☒ No ☐

3. NAME OF DECEASED (Type or print): First MARY Middle JANE Last DISMANG
4. DATE OF DEATH: Month JUNE Day 21 Year 1960
5. SEX: Female
6. COLOR OR RACE: White
7. Married ☐ Never Married ☐ Widowed ☒ Divorced ☐
8. DATE OF BIRTH: 5-31-1887
9. AGE (last birthday): 73
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: at home
11. BIRTHPLACE (City and state or country): Dukedom, Tennessee
12. CITIZEN OF WHAT COUNTRY: U.S.A.
13a. FATHER'S NAME: Mathew Ainley
13b. MOTHER'S MAIDEN NAME: Lou Allree
14. NAME OF HUSBAND OR WIFE: M.K.Dismang
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.: none
17. INFORMANT: Bert Dismang Address: 5254 Waterman Ave.

MEDICAL CERTIFICATION

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)	CONGESTIVE HEART FAILURE	2 WEEKS
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b)	CHRONIC CORONARY INSUFFICIENCY	2 WEEKS
DUE TO (c)	MILD ARTERIOSCLEROSIS AND CHRONIC HYPERTENSION	5-10 YEARS

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)
CARCINOMA OF SIGMOID COLON, POST-OPERATIVE
PYOMETRA, POST-OPERATIVE
420.1 H

PART III. If deceased was female was there a pregnancy in last 90 days. ☐ Yes ☒ No ☐ Unknown

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐
20a. ACCIDENT ☐ SUICIDE ☐ HOMICIDE ☐
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 ☐ NOT WHILE AT WORK ☐
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 MAY 17, 1960, to JUNE 21, 1960 and last saw her/him alive on JUNE 21, 1960
Death occurred at 11:30 A.M. m on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE: F.R. Bradley (Degree or title) M. D.
22b. ADDRESS: BARNES HOSPITAL
22c. DATE SIGNED: 6/22/60

23a. BURIAL, CREMATION, REMOVAL (Specify): Removal
23b. DATE: 6-23-60
23c. NAME OF CEMETERY OR CREMATORY: Ingram Cemetery.
23d. LOCATION (City, town, or county) (State): Posahontas, Arkansas
24. FUNERAL DIRECTOR: Politte ADDRESS: Crystal City, Mo.
25. DATE RECD. BY LOCAL REG.: JUN 22 1960
26. REGISTRAR'S SIGNATURE: Earl Smith, M.D.

(Licensed Embalmer's Statement on Reverse Side)

BY AFFIDAVIT OF DOCUMENT

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed b

or by _____, Student Embalmer No._____

working under my personal supervision.

Student_____ Signed Gentry R Politte

Signature of Student Embalmer

Licensed Embalmer No. 34

P. O. Address Crystal

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