

FRI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-60-027693

FILED VS JUL 27 1960

STATE FILE NUMBER

Registration District No. 226 Primary Registration District No. 4337 Registrar's No. 27

| | | | | | | | | | |
|--|---|---|---|--|---|--|---|--|--|
| 1. PLACE OF DEATH a. COUNTY <u>Monroe</u> | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> COUNTY <u>Monroe</u> | | | | | |
| b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Madison, Missouri</u> | | Length of stay in lb <u>10 years</u> | | c. CITY OR TOWN <u>Madison, Mo.</u> | | 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>West Marion Street</u> | | | Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> | | d. STREET ADDRESS (If outside, give location) <u>West Marion Street</u> | | Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> | | |
| 3. NAME OF DECEASED (Type or print) First <u>Aubrey</u> Middle <u>Huston</u> Last <u>Meals</u> | | | | 4. DATE OF DEATH Month <u>June</u> Day <u>26</u> Year <u>1960</u> | | | | | |
| 5. SEX <u>Male</u> | 6. COLOR OR RACE <u>White</u> | 7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/> | | 8. DATE OF BIRTH <u>2-11-1879</u> | 9. AGE (last birthday) <u>81</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>Retired farmer</u> | | | 10b. KIND OF BUSINESS OR INDUSTRY <u>Grain & Livestock</u> | | 11. BIRTHPLACE (City and state or country) <u>Madison, Mo.</u> | | 12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u> | | |
| 13a. FATHER'S NAME <u>Thomas O. Meals</u> | | | 13b. MOTHER'S MAIDEN NAME <u>Lucille Cottingham</u> | | | 14. NAME OF HUSBAND OR WIFE <u>Stella Meals</u> | | | |
| 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>702-09-8652</u> | | 17. INFORMANT <u>Stella Meals</u> | | | Address <u>Madison, Mo.</u> | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiac Arrest</u> | | | | | | | INTERVAL BETWEEN ONSET AND DEATH <u>Minutes</u> | | |
| Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <u>Hypertensive Heart Disease</u> | | | | | | | <u>years</u> | | |
| DUE TO (c) <u>Atherosclerosis</u> | | | | | | | <u>years</u> | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>Prostatic Hypertrophy</u> | | | | | | 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 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>None</u> | | | | | | |
| 20c. TIME OF INJURY Hour _____ a.m. _____ p.m. | <u>None</u> | | 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>None</u> | | 20f. CITY, TOWN, OR LOCATION <u>Madison</u> | | |
| | <u>None</u> | | | | COUNTY <u>Monroe</u> | | STATE <u>Mo</u> | | |
| 21. I attended the deceased from <u>July 1960</u> to <u>June 26 1960</u> and last saw him alive on <u>April 1960</u> . Death occurred at <u>his home</u> on the date stated above, and to the best of my knowledge, from the causes stated. | | | | | | | | | |
| 22a. SIGNATURE <u>E. J. Stueker D.O.</u> | | | | | 22b. ADDRESS <u>P.O. Box 979 Madison Mo.</u> | | 22c. DATE SIGNED <u>6-27-60</u> | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) | | 23b. DATE | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION (City, town, or county) | | 23e. (State) | | |
| <u>Burial</u> | | <u>6-28-1960</u> | <u>Sunset Hill</u> | | <u>Madison</u> | | <u>Mo.</u> | | |
| 24. FUNERAL DIRECTOR <u>Thompson-Mackler</u> | | | | ADDRESS <u>Madison, Mo.</u> | | 25. DATE RECD. BY LOCAL REG. <u>7-18-60</u> | | 26. REGISTRAR'S SIGNATURE <u>Elsie Miller</u> | |

(Licensed Embalmer's Statement on Reverse Side)

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

AUG 30 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 Joseph R. Mack
Licensed Embalmer No. 4571

P. O. Address Madison

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.