RI DIVISION OF HEALTH — STANDARD CERTIFICATE OF DEATH

-60-031460

STATE FILE NUMBER

LED VS SEP 7 1960

DED

Registration District No. 243 Primary Registration District No. 4364 Registrar's No. 37

1. PLACE OF DEATH a. COUNTY Newton	2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY McDonald
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Stella — Length of stay in 1b 2 days	c. CITY OR TOWN Anderson — Inside Limits Yes ☐ No ☐
c. FULL NAME OF HOSPITAL OR INSTITUTION (If NOT in hospital, give location) Cardwell Memorial Hosp. — Inside Limits Yes ☒ No ☐	d. STREET ADDRESS (If outside, give location) Rt. # 3 — Reside on Farm Yes ☒ No ☐

3. NAME OF DECEASED (Type or print)	First: William	Middle: Andrew	Last: Gideon	4. DATE OF DEATH	Month: Aug. Day: 3 Year: 1960
5. SEX: Male	6. COLOR OR RACE: White	7. Married ☒ Never Married ☐ Widowed ☐ Divorced ☐	8. DATE OF BIRTH: Feb. 29-1889	9. AGE (last birthday): 71	IF UNDER 1 YEAR: Months 5 Days 5 — IF UNDER 24 HR: Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Farmer	10b. KIND OF BUSINESS OR INDUSTRY: General	11. BIRTHPLACE (City and state or country): Rogers, Arkansas	12. CITIZEN OF WHAT COUNTRY: USA		
13a. FATHER'S NAME: Thomas Gideon	13b. MOTHER'S MAIDEN NAME: Nancy Hodson	14. NAME OF ~~HUSBAND~~ OR WIFE: Florence Russell			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No (If yes, give war or dates of service): None	16. SOCIAL SECURITY NO.: None	17. INFORMANT Address: Mrs. Florence Gideon, Anderson,			

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)	Cerebral hemorrhage	3 days
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b)	Arteriosclerosis &	3 years
DUE TO (c)	Hypertension	

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. ☐ 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 1958, to Aug 3, 60 and last saw her/him alive on Aug 3, 1960

Death occurred at 9:35P. m on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title): [signature] D.O.	22b. ADDRESS: Noel Mo	22c. DATE SIGNED: 8/18/60
23a. BURIAL, CREMATION, REMOVAL (Specify): Removal	23b. DATE: 8/3/1960	23c. NAME OF CEMETERY OR CREMATORY: Tracy Cemetery
23d. LOCATION (City, town, or county) (State): Anderson Rt. # 3, Mo.		
24. FUNERAL DIRECTOR ADDRESS: Robert C. Roller Anderson, Mo.	25. DATE RECD. BY LOCAL REG.: 8-20-60.	26. REGISTRAR'S SIGNATURE: Mildred Moherly

(Licensed Embalmer's Statement on Reverse Side)

BY AFFIDAVIT OF DOCUMENT

SEP 7 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_____ Signed_____

Signature of Student Embalmer

Licensed Embalmer No. 03458

P. O. Address Anderson,

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