SSOURI DIVISION OF HEALTH – STANDARD CERTIFICATE OF DEATH

-61-022170

STATE FILE NUMBER

AMENDED

Registration District No. 282 Primary Registration District No. _____ Registrar's No. 70

FILED JUN 20 1961

1. PLACE OF DEATH
a. COUNTY Polk
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Greene Township — Length of stay in 1b: 20 years
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Rural-Greene — Inside Limits: Yes ☐ No ☑
d. STREET ADDRESS (If outside, give location) Rural-Greene — Reside on Farm: Yes ☑ No ☐

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Missouri b. COUNTY Polk
c. CITY OR TOWN Louisburg — Inside Limits: Yes ☐ No ☑

3. NAME OF DECEASED (Type or print) First: Ida Middle: Last: Eidson

4. DATE OF DEATH Month: June Day: 8 Year: 1961

5. SEX: Female
6. COLOR OR RACE: White
7. Married ☐ Never Married ☐ Widowed ☑ Divorced ☐
8. DATE OF BIRTH: June 19, 1873
9. AGE (last birthday): 87
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: Homemaking
11. BIRTHPLACE (City and state or country): Missouri
12. CITIZEN OF WHAT COUNTRY: U.S.A.

13a. FATHER'S NAME: W. K. Jump
13b. MOTHER'S MAIDEN NAME: Sarah Arnold
14. NAME OF HUSBAND OR WIFE: Deceased

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service): No
16. SOCIAL SECURITY NO.: None
17. INFORMANT: Mrs. Onda Crain — Address: Louisburg, Mo. Rt. I

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Cerebral Embolism — INTERVAL BETWEEN ONSET AND DEATH: 2 days
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.
DUE TO (b) Arteriosclerosis — ?
DUE TO (c)

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 May 1, 1961 to June 8, 1961 and last saw ~~him~~ her alive on June 7, 1961
Death occurred at 12:01 P.M. on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE R. O. Hammon (Degree or title) M.D
22b. ADDRESS Buffalo, Mo
22c. DATE SIGNED 6-10-61

23a. BURIAL, CREMATION, REMOVAL (Specify) Burial
23b. DATE 6-10-61
23c. NAME OF CEMETERY OR CREMATORY Lindley Creek Cemetery
23d. LOCATION (City, town, or county) (State) Polk County, Mo.

24. FUNERAL DIRECTOR Sidney G. Pitts — ADDRESS Bolivar, Mo.
25. DATE RECD. BY LOCAL REG. 6-14-1961
26. REGISTRAR'S SIGNATURE Ralph Gordon for Judd Gordon

(Licensed Embalmer's Statement on Reverse Side)

DATE AMENDED | INSTEAD OF | SHOULD READ | ITEM NO. | DOCUMENT | BY AFFIDAVIT OF

AUG 15 1961

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or by _____, Student Embalmer No._____ working under my personal supervision.

Student_____
Signature of Student Embalmer

Signed Sidney J. Pitts

Licensed Embalmer No. 4939

P. O. Address Bolivar, Mo.

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.