

SOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-61-041971

STATE FILE NUMBER

AMENDED

Registration District No. 275 Primary Registration District No. 3053 Registrar's No. 249
FILED NOV 29 1961

1. PLACE OF DEATH a. COUNTY <u>Phelps</u> b. CITY (if outside corporate limits, give TOWNSHIP only) OR TOWN <u>Rolla</u> Length of stay in lb c. FULL NAME OF (if NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>Phelps Co Hospital</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> COUNTY <u>Phelps</u> c. CITY OR TOWN <u>St. James</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> d. STREET ADDRESS (If outside, give location) <u>116 W. Eldon St.</u> Residence on Farm Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Viola</u> Middle <u>Adelia</u> Last <u>Southard</u>		4. DATE OF DEATH Month <u>Nov</u> Day <u>21</u> Year <u>1961</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>white</u>	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <u>Feb 16, 1889</u>
9. AGE (last birthday) <u>72</u>		IF UNDER 1 YEAR Months <u>9</u> Days <u>5</u>	IF UNDER 24 HR Hours <u></u> Min. <u></u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (City and state or country) <u>St. James, Missouri</u>		12. CITIZEN OF WHAT COUNTRY <u>USA</u>	
13a. FATHER'S NAME <u>Jefferson Cox</u>		13b. MOTHER'S MAIDEN NAME <u>Rose Jahns</u>	
14. NAME OF HUSBAND OR WIFE <u>Edward</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. INFORMANT <u>Dolly Boyd, 116 W. Eldon, St. James, M</u>		17. ADDRESS	
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>acute left heart failure</u> DUE TO (b) <u>arteriosclerotic heart disease</u> DUE TO (c) <u>arteriosclerotic hypertension</u> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.			INTERVAL BETWEEN ONSET AND DEATH <u>2 days</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>cerebro. vasculat. atrophy</u>			PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input checked="" 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.)			
20c. TIME OF INJURY Hour <u></u> a.m. <u></u> p.m. <u></u> Month, Day, Year <u></u>			
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>11/19/61</u> to <u>11/21/61</u> and last saw her <u>her</u> alive on <u>11/21/61</u> Death occurred at <u>7:30 a.m.</u> on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree or title) <u>Adelia Southard</u>		22b. ADDRESS	
22c. DATE SIGNED <u>11/25/61</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE <u>Nov 24, 1961</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Masonic Cemetery</u>		23d. LOCATION (City, town, or county) (State) <u>St. James, Missouri</u>	
4. FUNERAL DIRECTOR <u> Jesse Gahr, 300 S. Main St. James, Mo.</u>		25. DATE RECD. BY LOCAL REG. <u>Nov. 25, 1961</u>	
26. REGISTRAR'S SIGNATURE <u>Nadine L. Stoll</u>			

DATE AMENDED

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

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 C. Jesse Gahr

Licensed Embalmer No. 4486
P. O. Address St. James

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.