

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-62-000011

STATE FILE NUMBER

Registration District No. 1 Primary Registration District No. 3000 Registrar's No. 36

AMENDED

FILED FEB 5 1962

1. PLACE OF DEATH a. COUNTY Adair		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Mo b. COUNTY Adair	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Kirksville		Length of stay in 1b 3 yrs	c. CITY OR TOWN Novinger Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Comm. Nur. Home # 1		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Middle Last GOLDIE M. ELSEA			4. DATE OF DEATH Month Day Year January 28 1962
5. SEX Female	6. COLOR OR RACE White	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH 2/10/75
9. AGE (last birthday) 86		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) Homemaker		10b. KIND OF BUSINESS OR INDUSTRY Own Home	11. BIRTHPLACE (City and state or country) Wapello Co., Iowa
12. CITIZEN OF WHAT COUNTRY U S		13a. FATHER'S NAME Randolph Bailey	
13b. MOTHER'S MAIDEN NAME Sarah Unk.		14. NAME OF HUSBAND OR WIFE Wm. M. Elsea, (Dec)	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No No		16. SOCIAL SECURITY NO. N O N E	17. INFORMANT Address Everett Elsea, Kirksville, Mo.
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bronchopneumonia DUE TO (b) Cerebral Encephalomalacia DUE TO (c) Cerebral Arteriosclerosis Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.			INTERVAL BETWEEN ONSET AND DEATH days months years
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a). Arteriosclerotic Heart Disease		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 a.m. p.m. Month, Day, Year	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 7-17-61 to 1-28-62 and last saw her alive on 1-28-62 Death occurred at 9:15 a m on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE George H. Scheurer D.O.		(Degree or title)	22b. ADDRESS Kirksville
22c. DATE SIGNED 1-30-62			
23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE 1/30/62	23c. NAME OF CEMETERY OR CREMATOR Novinger	23d. LOCATION (City, town, or county) (State) Novinger, Adair, Mo.
24. FUNERAL DIRECTOR Foster Memorial Home, Kirksville, Mo.		25. DATE RECD. BY LOCAL REG. 1-30-1962	26. REGISTRAR'S SIGNATURE Doris W. Rathff

AMENDMENTS ON THIS DOCUMENT
 INSTEAD OF
 DATE AMENDED
 BY AFFIDAVIT OF
 MEDICAL CERTIFICATION
 SCHEURER

GEORGE H. SCHEURER, D.O.

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 Novas E Foster

Licensed Embalmer No. 4742

P. O. Address Kirkwood, 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.