

RI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

FILED VS OCT 13 1959

59-032109

STATE FILE NUMBER

Registration District No. 137 Primary Registration District No. 3023 Registrar's No. 257

1. PLACE OF DEATH a. COUNTY <u>Henry</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Henry</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Clinton</u>		Length of stay in 1b <u>2 weeks</u>	c. CITY OR TOWN <u>Clinton</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>Lofton Nursing Home</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <u>208 W. Allen St</u> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print) First <u>David</u> Middle <u>Arthur</u> Last <u>Anglin</u>			4. DATE OF DEATH Month <u>Oct</u> Day <u>9</u> Year <u>1959</u>		
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5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. Married <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <u>Feb 20, 1895</u>	9. AGE (last birthday) <u>64</u>	IF UNDER 1 YEAR Months <u> </u> Days <u> </u>	IF UNDER 24 HR Hours <u> </u> Min. <u> </u>
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Mail Carrier</u>	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and state or country) <u>Warsaw, Mo</u>	12. CITIZEN OF WHAT COUNTRY <u>USA</u>
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13a. FATHER'S NAME <u>William R. Anglin</u>	13b. MOTHER'S MAIDEN NAME <u>Martha Loyd</u>	14. NAME OF HUSBAND OR WIFE <u>none</u>
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT <u>William Anglin</u> Address <u>Deepwater, Mo</u>
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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>cerebral hemorrhage</u>		INTERVAL BETWEEN ONSET AND DEATH <u>2 hr</u>
Conditions, if any, which gave rise to above cause (a), starting the underlying cause last.	DUE TO (b) <u>cerebral hemorrhage</u>	<u>3 wks.</u>
	DUE TO (c) <u>chronic hypertension</u>	

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. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
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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.)
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20c. TIME OF INJURY Hour <u> </u> a.m. <u> </u> p.m. <u> </u> Month, Day, Year <u> </u> <u> </u> <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
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21. I attended the deceased from 3-7-59 to 10-9-59 and last saw her her alive on 10-7-59
Death occurred at 12:45 P.M. on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) <u>[Signature]</u>	22b. ADDRESS <u>Clinton, Mo</u>	22c. DATE SIGNED <u>10/10/59</u>
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23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE <u>10-11-1959</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Englewood cemetery</u>	23d. LOCATION (City, town, or county) (State) <u>Clinton, Mo</u>
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24. FUNERAL DIRECTOR ADDRESS <u>Sickman & Dunning FH Clinton, Mo</u>	25. DATE RECD. BY LOCAL REG. <u>Oct. 10-1959</u>	26. REGISTRAR'S SIGNATURE <u>[Signature]</u>
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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

Robert L. Dunning

Licensed Embalmer No. 4710

P. O. Address Clinch

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.