

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

58-019058

STATE FILE NUMBER

FILED JUN 11 1958

Registration District No. 217 Primary Registration District No. 5786 Registrar's No. 43

Health,  
Welfare  
Public  
Service

300  
1-56

Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed. All diseases in Part I must be casually related. Coroner cannot certify to a death due to natural causes.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

1. PLACE OF DEATH a. COUNTY <b>Mississippi</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Missouri</b> b. COUNTY <b>Miss.</b>					
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>Charleston</b>		Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>		c. CITY OR TOWN <b>Charleston</b> <sup>6670</sup>		Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>			
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>Route 3</b>			Length of stay in lb <b>2 yrs.</b>		d. STREET ADDRESS (If outside, give location) <b>Route 3, Box 150</b>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First <b>Grace</b> Middle <b>Revelle</b> Last <b>Revelle</b>				4. DATE OF DEATH Month <b>May</b> Day <b>27</b> Year <b>1958</b>					
5. SEX <b>Female</b>	6. COLOR OR RACE <b>Col.</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> <b>Widowed</b>		8. DATE OF BIRTH <b>Oct. 15, 1890</b>		9. AGE (In years last birthday) <b>67</b>		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Farmer</b>			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (City and state or country) <b>N. Carolina</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>		
13. FATHER'S NAME <b>Isaac Smith</b>				14. MOTHER'S MAIDEN NAME <b>Agnes (Unk.)</b>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO.		17. INFORMANT Address <b>Charleston, Mo.</b> <b>Agnes Adkins, Route 3, Box 150.</b>					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary Vascular Accident</b>								INTERVAL BETWEEN ONSET AND DEATH <b>10 min</b>	
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.		DUE TO (b) <b>Hypertensive Heart disease - Decomp</b>		DUE TO (c) <b>Hypertension</b>		4501		1 month <b>7</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(n)								19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> <b>2</b>	
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 <b>April 28, 1958</b> to <b>May 27, 1958</b> and last saw her/him alive on <b>May 17, 1958</b> Death occurred at <b>11:30 A.M.</b> on the date stated above; and to the best of my knowledge, from the causes stated.									
22a. SIGNATURE <i>Edmond M. ...</i> (Degree or title)					22b. ADDRESS <i>Charleston, Mo.</i>			22c. DATE SIGNED <b>5/29/58</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE <b>June 5, 1958</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Oak Grove Cemetery</b>		23d. LOCATION (City, town, or county) (State) <b>Charleston, Missouri</b>				
24. FUNERAL DIRECTOR <i>L.R. Sparks</i> ADDRESS <b>Charleston, Mo.</b>			25. DATE RECD. BY LOCAL REG. <b>6-6-58</b>		26. REGISTRAR'S SIGNATURE <i>Dorothy B. ...</i>				

(Licensed Embalmer's Statement on Reverse Side)

RECEIVED  
Miss. Co. Health  
County File No. \_\_\_\_\_  
Date Filed 6-9-

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 Eddie Middleton.....

Licensed Embalmer No. 504

P. O. Address.....

Casey Girardeau,

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.