

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

58-021734
STATE FILE NUMBER

FILED JUN 30 1958

Registration District No. 140 Primary Registration District No. 3024 Registrar's No. 51

300
1-57

1. PLACE OF DEATH a. COUNTY Howard		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY Howard	
b. CITY OR TOWN Fayette		c. CITY OR TOWN Fayette	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Rest Haven		d. STREET ADDRESS (If outside, give location) Fayette	
3. NAME OF DECEASED (Type or print) First James Middle Monroe Last Rouse		4. DATE OF DEATH Month June Day 18 Year 1958	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> 2 DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH March 2, 1862
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Carpenter & Sawmill		10b. KIND OF BUSINESS OR INDUSTRY	9. AGE (In years last birthday) 96
11. BIRTHPLACE (City and state or country) Hallsville, Missouri		12. CITIZEN OF WHAT COUNTRY? USA	
13a. FATHER'S NAME John Rouse		13b. MOTHER'S MAIDEN NAME Edith Wainscott	
14. NAME OF HUSBAND OR WIFE Phnora M. Davis		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. Nora Derrieux, Fayette, 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) Acute cerebral hemorrhage			INTERVAL BETWEEN ONSET AND DEATH 4 1/2 hours
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. } DUE TO (b) _____ DUE TO (c) _____			331X
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)			19. WAS AUTOPSY PERFORMED? NO
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.		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 June 14 1958 to June 18 1958 and last saw him alive on 6-17-58 Death occurred at 10:15 A.M. on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE James J. DeMa		22b. ADDRESS Fayette, Mo.	
22c. DATE SIGNED 6-24-58		23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	
23b. DATE June 20, 58		23c. NAME OF CEMETERY OR CREMATORY Sulphur Springs Cem.	
23d. LOCATION (City, town, or county) Howard County, Missouri		24. FUNERAL DIRECTOR Markland - Hall ADDRESS New Franklin, Mo.	
25. DATE RECD. BY LOCAL REG. 6/24/58		26. REGISTRAR'S SIGNATURE Mary K. Shell	

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE
MEDICAL CERTIFICATION

All diseases in Part I must be causally related.

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 *Tom D. Markland*

Licensed Embalmer No. *4592*
P. O. Address *New Franklin*

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.