

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

58-028002

STATE FILE NUMBER

FILED JUL 29 1958

Registration District No. 360 Primary Registration District No. 6225 Registrar's No. 110

1. PLACE OF DEATH a. COUNTY <b>Vernon</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Missouri</b> b. COUNTY <b>Hickory</b>							
b. CITY (If outside corporate limits, give TOWNSHIP only) <b>Washington Township</b>		Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>		c. CITY OR TOWN <b>Wheatland</b>		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>State Hospital # 39 yrs, 9 mos.</b>			Length of stay in lb <b>13 days</b>		d. STREET ADDRESS (If outside, give location) <b>none</b>		Reside on Farm Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>				
3. NAME OF DECEASED (Type or print) First <b>Effie</b> Middle <b>I.</b> Last <b>Rickson</b>				4. DATE OF DEATH Month <b>July</b> Day <b>22</b> Year <b>1958</b>							
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> 2 DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>Nov. 15, 1878</b>		9. AGE (In years last birthday) <b>79 yrs. 8</b>		IF UNDER 1 YEAR Months <b>8</b> Days <b>7</b>		IF UNDER 24 HRS. Hours <b>7</b> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Unknown</b>			10b. KIND OF BUSINESS OR INDUSTRY <b>None</b>		11. BIRTHPLACE (City and state or country) <b>Berksville, Kentucky</b>			12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>			
13a. FATHER'S NAME <b>Unknown</b>				13b. MOTHER'S MAIDEN NAME <b>Unknown</b>				14. NAME OF HUSBAND OR WIFE <b>deceased</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. <b>none</b>		17. INFORMANT <b>Adm. Papers</b> 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) <b>Coronary Vessel Disease</b>								INTERVAL BETWEEN ONSET AND DEATH <b>Years</b>			
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. } DUE TO (b) <b>Chronic Brights Disease</b>								<b>Years</b>			
DUE TO (c) <b>592X</b>											
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? 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 <b>p.m.</b> 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 25, 1955</b> to <b>July 22, 1958</b> and last saw her/him alive on <b>July 22, 1958</b> Death occurred at <b>9:10 A.M.</b> on the date stated above; and to the best of my knowledge, from the causes stated.											
22a. SIGNATURE <b>E. Allen Pickens, M.D.</b>								22b. ADDRESS <b>State Hospital # 3</b>		22c. DATE SIGNED <b>7-22-58</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY				23d. LOCATION (City, town, or country) (State)			
<b>Burial</b>		<b>July 24-1958</b>		<b>Wright Creek Cemetery, Lower City, Mo.</b>							
24. FUNERAL DIRECTOR <b>Walter H. Thayer, Wheatland, Mo.</b>				25. DATE RECD. BY LOCAL REG. <b>7-23-58</b>		26. REGISTRAR'S SIGNATURE <b>Anna E. Jurey</b>					

Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed. All diseases in Part I must be causally related.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

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 *Chas. Gilbert Hathaway*

Licensed Embalmer No. *4267*

P. O. Address *W. Hartland, Me.*

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.