

Health,  
Welfare  
Public  
Service

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

59-000096  
STATE FILE NUMBER

FILED JAN 27 1959 Registration District No. 10 Primary Registration District No. 3002 Registrar's No. 16

300  
-57

1. PLACE OF DEATH a. COUNTY <b>Audrain</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before a. STATE <b>Missouri</b> b. COUNTY <b>Audrain</b> )	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>Mexico</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <b>Mexico</b> 00430 Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>Audrain Hospital</b>		Length of stay in 1b <b>45 yrs.</b>	d. STREET ADDRESS (If outside, give location) <b>922 S. Muldrow</b> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print) First Middle Last <b>Charles Edward Styles</b>			4. DATE OF DEATH Month Day Year <b>Jan. 16, 1959</b>		
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5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>July 22, 1887</b>	9. AGE (In years last birthday) <b>71</b>	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Carpenter</b>	10b. KIND OF BUSINESS OR INDUSTRY <b>Building</b>	11. BIRTHPLACE (City and state or country) <b>New York, New York</b>	12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>
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13a. FATHER'S NAME <b>Charles E. Styles</b>	13b. MOTHER'S MAIDEN NAME <b>Unknown</b>	14. NAME OF HUSBAND OR WIFE <b>Flora E. Styles</b>
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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) <b>No</b>	16. SOCIAL SECURITY NO. <b>491-05-7475</b>	17. INFORMANT <b>Mrs. Charles Styles</b>	Address <b>Mexico, Mo.</b>
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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) <b>Acute Myocardial Ischemia</b>		INTERVAL BETWEEN ONSET AND DEATH <b>12 hours</b>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) <b>Hypertensive Heart Disease</b>	<b>6 years</b>
	DUE TO (c) <b>Hypertension</b>	<b>44 3x 6 years</b>

PART II. OTHER SIGNIFICANT CONDITIONS/CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <b>Esophageal Hemorrhage due to Varix</b>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
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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 form 18.)
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20c. TIME OF INJURY Hour Month, Day, Year a.m. p.m.
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20d. INJURY OCCURRED WHILE AT <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 **1-3-59** to **1-16-59** and last saw <sup>him</sup> alive on **1-15-59**  
Death occurred at **5:30 a.m.** m on the date stated above; and to the best of my knowledge, from the causes stated.

22a. SIGNATURE <b>R. W. Swan</b> (Degree or title)	22b. ADDRESS <b>Mexico, Mo</b>	22c. DATE SIGNED <b>1-16-59</b>
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23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE <b>Jan. 18, 1959</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Eastlawn</b>	23d. LOCATION (City, town, or county) (State) <b>Mexico, Mo.</b>
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24. FUNERAL DIRECTOR <b>Precht-Hueston</b>	ADDRESS <b>Mexico, Mo.</b>	25. DATE RECD. BY LOCAL REG. <b>Jan. 17-1959</b>	26. REGISTRAR'S SIGNATURE <b>Blanche Neely</b>
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(Licensed Embalmers' Statement on Reverse Side)

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

All diseases in Part I must be causally related.

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 Earl J. Owen .....

Licensed Embalmer No. 3189 .....  
P. O. Address Mexico, 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.