Health, Welfare Public Service

300 -57 1

THE DIVISION OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

59-000154

STATE FILE NUMBER

FILED FEB 9 1959 Registration District No. 27 Primary Registration District No. 5097 Registrar's No. 14

1. PLACE OF DEATH
a. COUNTY: Bates
b. CITY OR TOWN (If outside corporate limits, give TOWNSHIP only): Shawnee Township — Inside Limits: Yes ☐ No ☒
c. FULL NAME OF HOSPITAL OR INSTITUTION (If NOT in hospital, give location): — Length of stay in Hospital: 68 Years

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Missouri b. COUNTY: Bates
c. CITY OR TOWN: 0078 — Inside Limits: Yes ☐ No ☐
d. STREET ADDRESS (If outside, give location): Shawnee Township — Reside on Farm: Yes ☒ No ☐

3. NAME OF DECEASED (Type or print): First: Verlinda Middle: Eliza Last: Gepford

4. DATE OF DEATH Month: Jan. Day: 29 Year: 1959

5. SEX: Female 1

6. COLOR OR RACE: White

7. MARRIED ☒ **NEVER MARRIED** ☐ **WIDOWED** ☐ **DIVORCED** ☐

8. DATE OF BIRTH: June 3 1890

9. AGE (In years last birthday): 68 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (City and state or country): Bates Co. Missouri 6

12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13a. FATHER'S NAME: Charles H. Moore

13b. MOTHER'S MAIDEN NAME: Anna Eliza Nuckols

14. NAME OF HUSBAND OR WIFE: Raymond H. Gepford.

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.: 490-42-3168

17. INFORMANT: R.H. Gepford. R.F.D. Butler, Mo.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:

		INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a)	Coronary thrombosis	15 min
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b)	arterio sclerosis	15 yrs
DUE TO (c)		

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a): 4201

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒ 2

20a. ACCIDENT ☐ **SUICIDE** ☐ **HOMICIDE** ☐

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 ☐ NOT WHILE AT WORK ☐

20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

20f. CITY, TOWN, OR LOCATION COUNTY STATE

All diseases in Part I must be causally related.

21. I attended the deceased from Died on my arrival, to _____ and last saw her/him alive on _____
Death occurred at 10:30 P.M. on the date stated above; and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title): D.S. Colson D.O. 2

22b. ADDRESS: Adrian Mo

22c. DATE SIGNED: Jan 30 1959

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE: 2-1-59

23c. NAME OF CEMETERY OR CREMATORY: Oak Hill Cemetery.

23d. LOCATION (City, town, or county) (State): Adrian, Mo.

24. FUNERAL DIRECTOR ADDRESS: Six Funeral Service. Adrian, Mo.

25. DATE RECD. BY LOCAL REG.: Feb 3-1959

26. REGISTRAR'S SIGNATURE: Kendell Torrey

(Licensed Embalmer's Statement on Reverse Side)

7 6

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 .....

Licensed Embalmer No. 3450

P. O. Address Adrian, 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.