

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

59-000858
STATE FILE NUMBER

FILED JAN 26 1959

Registration District No. 115-116 Primary Registration District No. 3020 Registrar's No. 17

300
1-57

1. PLACE OF DEATH a. COUNTY Franklin		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY Franklin	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Washington		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN Union
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION St. Francis Hos.		Length of stay in 1b 3 wks	d. STREET ADDRESS (If outside, give location) Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Edith Middle Pursley Last Pursley			4. DATE OF DEATH Month Jan. Day 18 Year 1959
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Aug. 27, 1877
9. AGE (In years last birthday) 81		IF UNDER 1 YEAR Months 0 Days 0	IF UNDER 24 HRS. Hours 0 Min. 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Home	11. BIRTHPLACE (City and state or country) Robertsville, Mo.
12. CITIZEN OF WHAT COUNTRY? USA		13a. FATHER'S NAME Matthew Bay	
13b. MOTHER'S MAIDEN NAME Elizabeth Wilson		14. NAME OF HUSBAND OR WIFE Frank Pursley	
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 Monroe Pursely
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) orthostatic pneumonia		INTERVAL BETWEEN ONSET AND DEATH 10 days	
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) Pneumothorax & R. b. Fractures			
DUE TO (c) Accidental fall - Senility 9040			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) 21		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT <input checked="" 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 2:00 p.m. Month, Day, Year Dec. 28, 1958			
20d. INJURY OCCURRED WHILE AT <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) home	
20f. CITY, TOWN, OR LOCATION Union 036 Franklin Mo.		COUNTY Franklin STATE Mo.	
21. I attended the deceased from Dec. 28, 1958 to 17 Jan 59 and last saw her alive on 17 Jan 59 Death occurred at 2:30 P. m on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE William R. Richardson, M.D.		22b. ADDRESS Union, Mo.	
22c. DATE SIGNED 19 Jan 59			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE Jan. 20, 1959	
23c. NAME OF CEMETERY OR CREMATORY Mt. Olive Cemetery		23d. LOCATION (City, town, or county) Robertsville, Mo.	
24. FUNERAL DIRECTOR Casey-Lenox		25. DATE RECD. BY LOCAL REG. 1/19/59	
ADDRESS St. Clair, Mo.		26. REGISTRAR'S SIGNATURE John J. Sudman, Registrar	

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

JAN 27

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 *J. M. Leno*

Licensed Embalmer No. *3601*

P. O. Address *St. Clair, Ill.*

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.