

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

59-000894

STATE FILE NUMBER

Registration District No. 118 Primary Registration District No. 4188 Registrar's No. 3

FILED FEB 9 1959

300
-57

1. PLACE OF DEATH a. COUNTY <u>Gasconade</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Gasconade</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Owensville</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <u>Owensville</u> <u>0370</u>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>her home</u>		Length of stay in lb <u>28 yrs.</u>	d. STREET ADDRESS (If outside, give location) <u>306 W. Washington</u>
Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>			

3. NAME OF DECEASED (Type or print) First <u>AMANDA</u> Middle <u>LEONA</u> Last <u>PICKER</u>			4. DATE OF DEATH Month <u>Feb.</u> Day <u>2</u> Year <u>1959</u>		
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5. SEX <u>female</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>May 8, 1877</u>	9. AGE (In years last birthday) <u>81</u>	IF UNDER 1 YEAR Months <u>0</u> Days <u>0</u>	IF UNDER 24 HRS. Hours <u>0</u> Min. <u>0</u>
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>housework</u>	10b. KIND OF BUSINESS OR INDUSTRY <u>own home</u>	11. BIRTHPLACE (City and state or country) <u>Summerfield, Mo.</u>	12. CITIZEN OF WHAT COUNTRY? <u>USA</u>
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13a. FATHER'S NAME <u>William Keeney</u>	13b. MOTHER'S MAIDEN NAME <u>Elisa Steward</u>	14. NAME OF HUSBAND OR WIFE <u>Charles Picker</u>
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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) <u>no</u>	16. SOCIAL SECURITY NO. <u>497-03-8773 B</u>	17. INFORMANT <u>Ida Picker</u>	Address <u>Owensville, Mo.</u>
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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) <u>Coronary Thrombosis</u>		INTERVAL BETWEEN ONSET AND DEATH <u>12 Hours</u>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) <u>Chronic Myocardial Degeneration</u>	<u>1 Year</u>
	DUE TO (c) <u>Generalized Arteriosclerosis</u>	<u>5 Years</u>

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH (but not related to the terminal disease condition given in PART I (a)) <u>Intertrochanteral Fracture of femur - 4 wks. 4 201F</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
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20a. ACCIDENT SUICIDE HOMICIDE <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)
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20c. TIME OF INJURY Hour <u> </u> Month, Day, Year a.m. <u> </u> p.m. <u> </u>	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 <u> </u> STATE <u> </u>
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21. I attended the deceased from <u>2-2-59</u> to <u>2-2-59</u> and last saw her alive on <u>2-2-59</u> Death occurred at <u>12:30 P.</u> m on the date stated above; and to the best of my knowledge, from the causes stated.

22a. SIGNATURE <u>Paras Bourne, M.D.</u> (Degree or title)	22b. ADDRESS <u>Owensville, Mo.</u>	22c. DATE SIGNED <u>2-3-59</u>
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23a. BURIAL, CREMATION, REMOVAL (Specify) <u>burial</u>	23b. DATE <u>2-5-1959</u>	23c. NAME OF CEMETERY OR CREMATORY <u>City Cemetery</u>	23d. LOCATION (City, town, or county) (State) <u>Owensville, Mo.</u>
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24. FUNERAL DIRECTOR <u>Willard H H Winter</u> ADDRESS <u>OWENSVILLE</u>	25. DATE RECD. BY LOCAL REG. <u>February 5, 1959</u>	26. REGISTRAR'S SIGNATURE <u>Mrs. Marvin Jappene</u>
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(Licensed Embalmer's Statement on Reverse Side)

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

All diseases in Part I must be causally related.

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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 Me....., Student Embalmer No. working under my personal supervision.

Student
Signature of Student Embalmer

Signed Myford H. Winter.....

Licensed Embalmer No. 383.....

P. O. Address OWENSVILLE.....

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.