

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

59-002022
STATE FILE NUMBER

FILED FEB 9 1959 Registration District No. 167 Primary Registration District No. 3040 Registrar's No. 41

1. PLACE OF DEATH a. COUNTY Livingston		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY Caldwell	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Chillicothe Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		c. CITY OR TOWN Breckenridge Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Chillicothe hosp.		Length of stay in 1b 4 days	
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 MARY Middle HALSTEAD Last CHAFFIN			4. DATE OF DEATH 2/1/1959 Month Day Year		
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 3/2/1874	9. AGE (In years last birthday) 85 IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housekeeper		10b. KIND OF BUSINESS OR INDUSTRY same	11. BIRTHPLACE (City and state or country) Breckenridge, Mo.		12. CITIZEN OF WHAT COUNTRY? U. S. A.
13. FATHER'S NAME Joseph Halstead			14. MOTHER'S MAIDEN NAME Margaret Wickliff		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) none		16. SOCIAL SECURITY NO. none	17. INFORMANT Address Mary W. Chaffin, Breckenridge, Mo.		

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Pneumonia, Terminal, Bilateral</i>		INTERVAL BETWEEN ONSET AND DEATH 12 hrs
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) <i>Fractured hip, nailed Jan 30-59</i>	4 days
	DUE TO (c) <i>Arterial Sclerosis, Severe</i>	4 yrs
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 Month, Day, Year a. m. p. m.		
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 C13

21. I attended the deceased from Aug 1-58 to Feb 1-59 and last saw her alive on Feb 1-59
Death occurred at 8:30/PM, m on the date stated above; and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) Joseph A. Conrad M.D.	22b. ADDRESS Chillicothe, Mo	22c. DATE SIGNED Feb 3-59
23a. BURIAL, CREMATION, REMOVAL (Specify) burial	23b. DATE 2/4/1959	23c. NAME OF CEMETERY OR CREMATORY Rose Hill cemetery
		23d. LOCATION (City, town, or county) (State) Breckenridge, Mo.

24. FUNERAL DIRECTOR Michael Funeral Chapel, Breckenridge Mo.	ADDRESS	25. DATE RECD. BY LOCAL REG. No. 2-3-59	26. REGISTRAR'S SIGNATURE Frances B Neill
---	---------	---	---

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. Coroner cannot certify to a death due to natural causes.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

300
1-56

Health,
Welfare
Public
Service

- 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..... *Gene C. Michael*

Licensed Embalmer No. *43*

P. O. Address... *Braymer*

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.