Health, & Welfare Public Service

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THE DIVISION OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

59-002043
STATE FILE NUMBER

FILED FEB 9 1959 Registration District No. 167 Primary Registration District No. 3040 Registrar's No. 39

1. PLACE OF DEATH
a. COUNTY Livingston
b. CITY OR TOWN Chillicothe — Inside Limits Yes [X] No [ ]
c. FULL NAME OF HOSPITAL OR INSTITUTION Susans Nursing Home — Length of stay in Ib 2 weeks

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Mo. b. COUNTY Carroll
c. CITY OR TOWN Carrollton — Inside Limits Yes [X] No [ ]
d. STREET ADDRESS (If outside, give location) 510 N. Leslie — Reside on Farm Yes [ ] No [X]

3. NAME OF DECEASED (Type or print) First ROXIE Middle Last RACHFORD
4. DATE OF DEATH Month Jan. Day 31 Year 1959
5. SEX Female
6. COLOR OR RACE White
7. MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ]
8. DATE OF BIRTH Mar. 25, 1876
9. AGE (In years last birthday) 82 — 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) At home
10b. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (City and state or country) Unionville, Mo.
12. CITIZEN OF WHAT COUNTRY? U.S.A.
13a. FATHER'S NAME Samuel Brice
13b. MOTHER'S MAIDEN NAME Jane Montgomery
14. NAME OF HUSBAND OR WIFE J.D. Rachford
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no (If yes, give war or dates of service)
16. SOCIAL SECURITY NO. none
17. INFORMANT Address Mrs. Robert Haywood, Carrollton, Mo.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Chr Myocarditis — INTERVAL BETWEEN ONSET AND DEATH
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.
DUE TO (b)
DUE TO (c)
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) Chr. Pyonephrosis 4222
19. WAS AUTOPSY PERFORMED? YES [ ] NO [X]
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
21. I attended the deceased from Jan 15 1959 to Jan 31 and last saw her alive on Jan 31, 1959
Death occurred at 6:30 A.M. on the date stated above; and to the best of my knowledge, from the causes stated.
22a. SIGNATURE (Degree or title) A. McDowell, M.D.
22b. ADDRESS Chillicothe Mo
22c. DATE SIGNED 2/2/59

23a. BURIAL, CREMATION, REMOVAL (Specify) Burial
23b. DATE 2/2/1959
23c. NAME OF CEMETERY OR CREMATORY Oak Hill Cem.
23d. LOCATION (City, town, or county) (State) Carrollton Mo.
24. FUNERAL DIRECTOR ADDRESS Standley-Gibson, Carrollton, Mo.
25. DATE RECD. BY LOCAL REG. 2/2/59.
26. REGISTRAR'S SIGNATURE Frances B Neill

(Licensed Embalmer's Statement on Reverse Side)

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

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.

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 Ben W. Gibson

Licensed Embalmer No. 7961

P. O. Address Carrollton

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.