

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

59-002152
STATE FILE NUMBER

FILED FEB 5 1959 Registration District No. 217 Primary Registration District No. 3045 Registrar's No. 12

1. PLACE OF DEATH a. COUNTY <u>Mississippi</u>			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Mississippi</u>		
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Charleston, Mo.</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <u>Charleston, Mo.</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>Home</u>		Length of stay in lb <u>Life</u>	d. STREET ADDRESS (If outside, give location) <u>205 S. 5th</u>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <u>Wm.</u> Middle <u>Washington</u> Last <u>Golightly</u>			4. DATE OF DEATH Month <u>Jan</u> Day <u>24</u> Year <u>1959</u>		
5. SEX <u>Male</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>Mar 9/1867</u>	9. AGE (In years last birthday) <u>91</u> IF UNDER 1 YEAR: Months <u>06</u> Days <u>12</u> IF UNDER 24 HRS.: Hours <u>0</u> Min. <u>0</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Mill. Operator</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Milling</u>	11. BIRTHPLACE (City and state or country) <u>Helena, Ark.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>
13a. FATHER'S NAME <u>Geo W. Golightly</u>		13b. MOTHER'S MAIDEN NAME <u>Mary Jane Wyatt</u>		14. NAME OF HUSBAND OR WIFE <u>Jennie L. Golightly</u>	
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>---</u>	17. INFORMANT Address <u>Mrs. Stella Lingle Charleston, MO</u>		
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>Bronchopneumonia</u> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. } DUE TO (b) <u>Uremia</u> DUE TO (c) <u>---</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>arricular fibrillation</u>					INTERVAL BETWEEN ONSET AND DEATH <u>3 weeks</u> <u>3 weeks</u>
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 <u>---</u> Month, Day, Year a.m. <u>---</u> p.m. <u>---</u>					
20d. INJURY OCCURRED WHILE AT <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
21. I attended the deceased from <u>1-8-59</u> to <u>1-24-59</u> and last saw her/him alive on <u>1-20-59</u> Death occurred at <u>3:30 A.M.</u> m on the date stated above; and to the best of my knowledge, from the causes stated.					
22a. SIGNATURE <u>W. Davis MD</u> (Degree or title)			22b. ADDRESS <u>Charleston Mo</u>		22c. DATE SIGNED <u>1-28-59</u>
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE <u>1/25/59</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Oak Grove</u>		23d. LOCATION (City, town, or county) (State) <u>Charleston, Mo.</u>
24. FUNERAL DIRECTOR <u>Mc Mikle Charleston, Mo.</u> ADDRESS		25. DATE RECD. BY LOCAL REG. <u>1-30-59</u>		26. REGISTRAR'S SIGNATURE <u>Donald B. Hathorn</u>	

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

300
1-57

All diseases in Part I must be causally related.

RECEIVED

Miss. Co. Health Dept

County File No. _____

Date Filed 2-4-59

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 [Handwritten Signature]

Licensed Embalmer No. 4695
P. O. Address [Handwritten Address]

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.