

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

59-002346

STATE FILE NUMBER

Health,
Welfare
Public
Service

FILED JAN 19 1959

Registration District No. 274 Primary Registration District No. 3052 Registrar's No. 25

300
1-57

1. PLACE OF DEATH a. COUNTY <u>Pettis</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Pettis</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Sedalia</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <u>Higginsville 08cc</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>711 North Missouri Sedalia Rest Home</u>		Length of stay in lb <u>3 weeks</u>	d. STREET ADDRESS (If outside, give location) <u>none</u> Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <u>CHARLES</u> Middle <u>BENJAMIN</u> Last <u>ANGLE</u>			4. DATE OF DEATH Month <u>Jan.</u> Day <u>14,</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>Oct. 30, 1866</u>
9. AGE (In years last birthday) <u>92</u>		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) <u>Minister</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Methodist Church</u>	11. BIRTHPLACE (City and state or country) <u>Franklin County, Virginia</u>
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13a. FATHER'S NAME <u>Joseph Marion Angle</u>	
13b. MOTHER'S MAIDEN NAME <u>Patience Zeigler</u>		14. NAME OF HUSBAND OR WIFE <u>Mary Susan Walker, dec'd.</u>	
15. WAS DECEASED EVER IN U. S. ARMY, NAVY, AIR FORCE, MARINE CORPS, OR COAST GUARD? (Yes, no, or unknown) (If yes, give war or dates of service) <u>NO</u>		16. SOCIAL SECURITY NO. <u>none</u>	17. INFORMANT Address <u>Mrs. Evelyn Wasson, Rt. 4, Sedalia, 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>Circulatory collapse</u> DUE TO (b) <u>Acute Myelocytic Leukemia</u> DUE TO (c) _____ Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>2042</u>			INTERVAL BETWEEN ONSET AND DEATH <u>12 hrs.</u> <u>2 mos.</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 _____ a.m. _____ p.m. _____		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>Dec. 27, 1958</u> to <u>Jan 14, 1959</u> and last saw ^{her} alive on <u>Jan 13, 1959</u> Death occurred at <u>8:30 P.M.</u> on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree or title) <u>Howell, D.D. 2</u>		22b. ADDRESS <u>1709 W Broadway Sedalia, Mo.</u>	22c. DATE SIGNED <u>Jan. 17, 1959</u>
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE <u>1/17/59</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Crown Hill Cemetery</u>	23d. LOCATION (City, town, or country) (State) <u>Sedalia, Missouri</u>
24. FUNERAL DIRECTOR <u>Shane King</u> ADDRESS <u>Sedalia, Mo.</u>		25. DATE RECD. BY LOCAL REG. <u>Jan 16 1959</u>	26. REGISTRAR'S SIGNATURE <u>Frances Shelby</u>

(Licensed Embalmers Statement on Reverse Side)

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

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 *P. E. Baker*

Licensed Embalmer No. *2419*

P. O. Address *Sedalia, Mo.*

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.