Health, Welfare Public Service

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THE DIVISION OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

59-002399
STATE FILE NUMBER

FILED JAN 27 1959 Registration District No. 275 Primary Registration District No. 3053 Registrar's No. 7

1. PLACE OF DEATH
a. COUNTY Phelps
b. CITY OR TOWN Rolla — Inside Limits: Yes ☑ No ☐
c. FULL NAME OF HOSPITAL OR INSTITUTION McFarland Nursing Home — Length of stay in Hospital 3 Mo.

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Missouri b. COUNTY Osage
c. CITY OR TOWN Folk 0760 — Inside Limits: Yes ☐ No ☒
d. STREET ADDRESS (If outside, give location) Jackson Twp — Reside on Farm: Yes ☒ No ☐

3. NAME OF DECEASED (Type or print) First Minnie Middle Josephine Last Courtwright

4. DATE OF DEATH Month Jan Day 13 Year 1959

5. SEX Female
6. COLOR OR RACE White
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH 2/7/1886
9. AGE (In years last birthday) 72 — 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) Housewife
10b. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (City and state or country) Osage Bluff, Mo
12. CITIZEN OF WHAT COUNTRY? USA

13a. FATHER'S NAME Antone Siebeneck
13b. MOTHER'S MAIDEN NAME Catherine Mizell
14. NAME OF HUSBAND OR WIFE George D. Courtwright

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) — (If yes, give war or dates of service)
16. SOCIAL SECURITY NO. None
17. INFORMANT Geo. D. Courtwright — Address Folk, Mo

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

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) Intestinal obstruction — INTERVAL BETWEEN ONSET AND DEATH: 3 days
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.
DUE TO (b) Probably malignant - (not definite)
DUE TO (c)
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) Senility 1539

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

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 10-13- to 58 and last saw her alive on 1-12-59
Death occurred at 6 A m on the date stated above; and to the best of my knowledge, from the causes stated.

22a. SIGNATURE E. E. Feind (Degree or title) M.D.
22b. ADDRESS Rolla Mo.
22c. DATE SIGNED 1-16-59

23a. BURIAL, CREMATION, REMOVAL (Specify) Burial
23b. DATE 1/15/59
23c. NAME OF CEMETERY OR CREMATORY Meta Southside
23d. LOCATION (City, town, or county) (State) Meta, Mo

24. FUNERAL DIRECTOR Walter L. Hedges — ADDRESS Hedges Funeral Homes, Iberia, Mo
25. DATE RECD. BY LOCAL REG. Jan. 19, 1959
26. REGISTRAR'S SIGNATURE Nadine L. Stoll

(Licensed Embalmer's Statement on Reverse Side)

All diseases in Part I must be causally related.

Date Filed January 26, 1959

FEB 3 1959

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 Walter P. Hedges

Licensed Embalmer No. 4265

P. O. Address Theria, 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.