

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

59-004164

STATE FILE NUMBER

FILED JAN 28 1959 Registration District No. 340 Primary Registration District No. 6152 Registrar's No. 10

S. 300  
1-57

4

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

1. PLACE OF DEATH a. COUNTY Stoddard		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Mo. COUNTY Stoddard	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Dexter (Rural) Liberty Twp.		c. CITY OR TOWN Dexter Rt. 1	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Green Meadows Rest Home		d. STREET ADDRESS Rt. 1	
3. NAME OF DECEASED (Type or print) Adeline Yielding		4. DATE OF DEATH Jan. 12-1959	
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 Dec. 10-1875
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired		10b. KIND OF BUSINESS OR INDUSTRY XX	9. AGE (In years last birthday) 83
11a. FATHER'S NAME Ab Bryant		11b. MOTHER'S MAIDEN NAME Unknown	11c. NAME OF HUSBAND OR WIFE Deceased
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, unknown) (If yes, give no. or dates of service) No. XX		16. SOCIAL SECURITY NO. Nine	17. INFORMANT Address Mrs. Sherman Morgan Dexter Rt. 1
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CEREBRAL THROMBOSIS			INTERVAL BETWEEN ONSET AND DEATH 1 MO.
Conditions, if any, which gave rise to above cause (a), starting 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)			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 <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 20 DEC 1958 to 11 Jan 1959 and last saw her alive on 11 Jan 1959 Death occurred at 3:00 A m on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree or title) James H. Turner M.D.		22b. ADDRESS Dexter Mo.	22c. DATE SIGNED 1/16/59
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE 1-13-59	23c. NAME OF CEMETERY OR CREMATORY Oak Ridge Cemetery	23d. LOCATION (City, town, or county) (State) Kennett Mo.
24. FUNERAL DIRECTOR ADDRESS Lentz Service Kennett Mo.		25. DATE RECD. BY LOCAL REG. 1-14-59	26. REGISTRAR'S SIGNATURE Velma D. Jenkins

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 *Edgar F. Ford* .....

Licensed Embalmer No. *4433* .....

P. O. Address *Mass.* .....

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.