Health, Welfare Public Service

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THE DIVISION OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

59-004211
STATE FILE NUMBER

FILED FEB 10 1959 Registration District No. 353 Primary Registration District No. 6196 Registrar's No. 3

1. PLACE OF DEATH
a. COUNTY: Texas
b. CITY OR TOWN (If outside corporate limits, give TOWNSHIP only): Licking — Inside Limits: Yes [X] No [ ]
c. FULL NAME OF HOSPITAL OR INSTITUTION (If NOT in hospital, give location): — Length of stay in 1b:

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

3. NAME OF DECEASED (Type or print): First: Edith — Middle: A. — Last: Vestal

4. DATE OF DEATH: Month: Feb — Day: 2 — Year: 1959

5. SEX: F — **6. COLOR OR RACE**: W — **7. MARRIED** [ ] **NEVER MARRIED** [ ] **WIDOWED** [X] **DIVORCED** [ ]

8. DATE OF BIRTH: Feb 15, 1880

9. AGE (In years last birthday): 78 — 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): House Work.
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (City and state or country): Texas Co. Mo
12. CITIZEN OF WHAT COUNTRY?: US

13a. FATHER'S NAME: W.S. Baker
13b. MOTHER'S MAIDEN NAME: Minnie Davis
14. NAME OF HUSBAND OR WIFE: Deceased

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.:
17. INFORMANT: Paul Vestal — Address: Licking Mo

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): cardiac & pulmonary arrest — INTERVAL BETWEEN ONSET AND DEATH:
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.
DUE TO (b): congestive heart failure — 6 months
DUE TO (c): cardio vascular renal disease
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a): Uremic pneumonia. 4 d 2 x
19. WAS AUTOPSY PERFORMED? YES [ ] NO [X]

MEDICAL CERTIFICATION

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 1953, to Feb 1959 and last saw her/him alive on Feb 1, 1959
Death occurred at 2:30 AM on the date stated above; and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title): B. J. Myers DO
22b. ADDRESS: Licking, Mo
22c. DATE SIGNED: 2-3-59

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE: 2-4-59
23c. NAME OF CEMETERY OR CREMATORY: Boonslick Cem.
23d. LOCATION (City, town, or county): Texas Co. (State): Mo

24. FUNERAL DIRECTOR: Smith Ferguson — ADDRESS: Licking Mo
25. DATE RECD. BY LOCAL REG.: Feb. 5, 1959
26. REGISTRAR'S SIGNATURE: Mrs. Elnora Hesse

(Licensed Embalmer's Statement on Reverse Side)

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

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 Robert E. Ferguson

Licensed Embalmer No. 3945

P. O. Address Pickering M

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.