Health, Welfare Public Service

THE DIVISION OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

59-004247

STATE FILE NUMBER

FILED JAN 27 1959 Registration District No. 360 Primary Registration District No. 6216 Registrar's No. 8

1. PLACE OF DEATH
a. COUNTY: Vernon
b. CITY OR TOWN (If outside corporate limits, give TOWNSHIP only): Walker Twp. — Inside Limits: Yes ☐ No ☒
c. FULL NAME OF HOSPITAL OR INSTITUTION (If NOT in Hospital give location): Rt.2 Walker,Mo. — Length of stay in Hospital:

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

3. NAME OF DECEASED (Type or print): First: Bessie Middle: Mae Last: Christy

4. DATE OF DEATH: Month: January Day: 18 Year: 1959

5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: 3-17-1877
9. AGE (In years last birthday): 81 — IF UNDER 1 YEAR: Months: 10 Days: 7 — 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): Elliston,Iowa
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13a. FATHER'S NAME: Coleman Hollingsworth
13b. MOTHER'S MAIDEN NAME: Eliza Richards
14. NAME OF HUSBAND OR WIFE: Roy Christy

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): no (If yes, give war or dates of service): none
16. SOCIAL SECURITY NO.: none
17. INFORMANT: Mrs.Ada White,Daughter Address: Lees Summitt Missouri

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) Probably Coronary Occlusion — INTERVAL BETWEEN ONSET AND DEATH: 10 min
Conditions, if any, which gave rise to above cause (a), stating 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): Body had no known medical attention past 20 years 4201

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 ____, to ____ and last saw her/him alive on ____
Death occurred at ____ m on the date stated above; and to the best of my knowledge, from the causes stated.

22a. SIGNATURE: Robert Porter (Degree or title): Coroner 3
22b. ADDRESS: Nevada. Mo.
22c. DATE SIGNED: 1-19-59

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE: 1-19-1959
23c. NAME OF CEMETERY OR CREMATORY: Newton Burial Park
23d. LOCATION (City, town, or county) (State): Nevada, Missouri

24. FUNERAL DIRECTOR ADDRESS: Hays Funeral Service,Inc. Nevada, Missouri
25. DATE RECD. BY LOCAL REG.: 1-20-1959
26. REGISTRAR'S SIGNATURE: Omal E. Jerry

(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 Richard L. Griffin

Licensed Embalmer No. 3053

P. O. Address [illegible]

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER [redacted] 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.