

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

59-005359

STATE FILE NUMBER

Registration District No. 141 Primary Registration District No. 5551 Registrar's No. 21

FILED MAR 16 1959

1. PLACE OF DEATH a. COUNTY <u>Howell</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Howell</u>	
b. CITY OR TOWN <u>West Plains</u> Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>		c. CITY OR TOWN <u>West Plains</u> 0468 Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
c. FULL NAME OF (IF NOT in hospital, give location) HOSPITAL OR INSTITUTION <input checked="" type="checkbox"/>		d. STREET ADDRESS (If outside, give location) <u>Rte 2-</u> Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>	

3. NAME OF DECEASED (Type or print) First Middle Last <u>Artie De Moise</u>			4. DATE OF DEATH Month Day Year <u>3-3-1959</u>		
5. SEX <u>♂</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>5/30-1896</u>		9. AGE (In years for birthday) <u>62</u> Months <u>7</u> Days <u>3</u> Hours <u></u> Min. <u></u>

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>none</u>		10b. KIND OF BUSINESS OR INDUSTRY <input checked="" type="checkbox"/>		11. BIRTHPLACE (City and state or country) <u>Waverly Mo</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13a. FATHER'S NAME <u>Gas De Moise</u>			13b. MOTHER'S MAIDEN NAME <u>Ann Clumpigbeard</u>			14. NAME OF HUSBAND OR WIFE <input checked="" type="checkbox"/>	

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <input checked="" type="checkbox"/>		16. SOCIAL SECURITY NO. <input checked="" type="checkbox"/>		17. INFORMANT <u>Mrs. Ann Anderson, West Plains Mo</u> Address <u></u>	
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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>U. REMIA,</u>			INTERVAL BETWEEN ONSET AND DEATH <u>3 MONTHS</u> <u>YEARS</u>
DUE TO (b) <u>HYPERTENSIVE CARDIO-VASCULAR</u>			
DUE TO (c) <u>RENAL DISEASE</u>			

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH (not related to the terminal disease condition given in PART I (a)) <u>SENILITY - CACHEXIA</u> <u>442x</u>			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
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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.) <u></u>	
20c. TIME OF INJURY Hour a.m. <u></u> Month, Day, Year <u></u> p.m. <u></u>			

20d. INJURY OCCURRED WHILE AT WORK <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.) <u></u>	20f. CITY, TOWN, OR LOCATION <u></u> COUNTY <u></u> STATE <u></u>
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21. I attended the deceased from <u>Oct 7, 1958</u> to <u>3-3-59</u> and last saw her alive on <u>3-2-59</u> Death occurred at <u>7:00 P.M.</u> m on the date stated above; and to the best of my knowledge, from the causes stated.	
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22a. SIGNATURE <u>Jack H. Wilson M.D.</u> (Degree or title) <u>C1</u>	22b. ADDRESS <u>West Plains, Mo</u>	22c. DATE SIGNED <u>3-11-59</u>
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23a. BURIAL, CREMATION, REMOVAL (Specify) <u></u>	23b. DATE <u>3-5-1959</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Flora</u>	23d. LOCATION (City, town, or county) (State) <u>West Plains Ark</u>
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24. FUNERAL DIRECTOR <u>Robertson, West Plains Mo</u> ADDRESS <u></u>	25. DATE RECD. BY LOCAL REG. <u>3-13-59</u>	26. REGISTRAR'S SIGNATURE <u>Beatrice Cook</u>
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USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

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 *A. S. Roberts*

Licensed Embalmer No. *3427*

P. O. Address *West Haven*

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.