

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

59-006291

STATE FILE NUMBER

Registration District No. 179 Primary Registration District No. 5667 Registrar's No. 23

Health, Welfare and Public Service

300
-57

1. PLACE OF DEATH a. COUNTY <u>LINCOLN</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MISSOURI</u> b. COUNTY <u>LINCOLN</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>BEDFORD</u>		Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	c. CITY OR TOWN <u>SILEX</u> e 578 Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
c. FULL NAME OF (IF NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>LCM HOSP.</u>		Length of stay in lb <u>2 WKS</u>	d. STREET ADDRESS (If outside, give location) <u>RFD</u> Reside on Farm Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <u>ABNER</u> Middle <u>WILLIAM</u> Last <u>MOMPHARD</u>			4. DATE OF DEATH Month <u>FEB.</u> Day <u>21</u> Year <u>1959</u>
5. SEX <u>Male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <u>JAN. 22, 1905</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>TRUCK DRIVER</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>LIVESTOCK</u>	9. AGE (In years last birthday) <u>54</u> IF UNDER 1 YEAR: Months _____ Days _____ IF UNDER 24 HRS.: Hours _____ Min. _____
11. BIRTHPLACE (City and state or country) <u>SILEX, Mo</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13a. FATHER'S NAME <u>HENRY R. Momphard</u>		13b. MOTHER'S MAIDEN NAME <u>NANCY COX</u>	14. NAME OF HUSBAND OR WIFE - DIVORCED <u>RUTH (WELCH) Momphard</u>
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>NO</u>		16. SOCIAL SECURITY NO. <u>NOT AVAILABLE</u>	
17. INFORMANT <u>WILLIAM Momphard - SILEX, Mo.</u>		Address	
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>MASSIVE CEREBRAL HEMORRAGE</u>			INTERVAL BETWEEN ONSET AND DEATH <u>10 DAYS</u>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <u>HYPERTENSIVE VASCULAR Dis.</u>			<u>UNK</u>
DUE TO (c) <u>ARTERIOSCLEROTIC VASCULAR Dis</u>			<u>UNK</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>331X</u>			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 <u>FEB 7, 1959</u> to <u>FEB 21, 1959</u> and last saw him alive on <u>FEB 20, 1959</u> Death occurred at <u>3:30 PM.</u> m on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE <u>Paul T. Berry M.D.</u> (Degree or title)		22b. ADDRESS <u>1 Roy, Mo.</u>	22c. DATE SIGNED <u>2/25/59</u> (State)
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	23b. DATE <u>FEB. 23, 1959</u>	23c. NAME OF CEMETERY OR CREMATORY <u>SULPHUR LICK</u>	23d. LOCATION (City, town, or county) (State) <u>RFD - SILEX, Mo.</u>
24. FUNERAL DIRECTOR <u>O. C. RICKS</u>		ADDRESS <u>ELSBERRY, Mo.</u>	25. DATE RECD. BY LOCAL REG. <u>2-27-59</u>
		26. REGISTRAR'S SIGNATURE <u>Charlotte Leek</u>	

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 

Licensed Embalmer No. 4012

P. O. Address Esberry, 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.