

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

STATE FILE NUMBER

59-006737

Health,
Welfare
Public
Service

Registration District No. 297 Primary Registration District No. 6021 Registrar's No. 23

300
1-57

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| 1. PLACE OF DEATH a. COUNTY <u>RAY</u> | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Mo.</u> b. COUNTY <u>RAY</u> | |
| b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>GRAPE GROVE Twp.</u> Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> | | c. CITY OR TOWN <u>GRAPE GROVE Twp.</u> 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>Home</u> Length of stay in lb <u>50 yrs.</u> | | d. STREET ADDRESS (If outside, give location) <u>9 mi NORTH OF HARDIN</u> Reside on Farm Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> | |

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| 3. NAME OF DECEASED (Type or print) First Middle Last <u>TRESSIE</u> — <u>EARLY</u> | | | 4. DATE OF DEATH Month Day Year <u>FEB. 5, 1959</u> | | |
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| 5. SEX <u>male</u> | 6. COLOR OR RACE <u>White</u> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>MAY 20, 1889</u> | 9. AGE (In years last birthday) <u>69</u> | IF UNDER 1 YEAR Months Days Hours Min. | IF UNDER 24 HRS. Hours Min. |
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| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u> | 10b. KIND OF BUSINESS OR INDUSTRY — | 11. BIRTHPLACE (City and state or country) <u>CARROLL COUNTY, Mo.</u> | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u> |
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| 13a. FATHER'S NAME <u>GEORGE ELLIOT</u> | 13b. MOTHER'S MAIDEN NAME <u>DRUCILLA DUNCAN</u> | 14. NAME OF HUSBAND OR WIFE <u>BEN EARLY</u> |
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| 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. — | 17. INFORMANT Address <u>CLYDE EARLY - HARDIN, Mo.</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>Coronary Thrombosis</u> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. } DUE TO (b) <u>Coronary arteriosclerosis</u> DUE TO (c) <u>Diabetes Mellitus</u> | | INTERVAL BETWEEN ONSET AND DEATH <u>few months</u> <u>many years</u> <u>many years</u> |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>260X</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.) — |
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| 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 — |
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| 21. I attended the deceased from <u>Sept. 26, 1958</u> to <u>Feb. 5, 1959</u> and last saw ^{her} _{him} alive on <u>Feb. 3, 1959</u> Death occurred at <u>12:50 P.</u> m on the date stated above; and to the best of my knowledge, from the causes stated. |
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| 22a. SIGNATURE (Degree or title) <u>J. E. Gosselberg M.D.</u> | 22b. ADDRESS <u>Braymer, Mo.</u> | 22c. DATE SIGNED <u>Feb. 7, 1959</u> |
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| 23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | 23b. DATE <u>2-8-59</u> | 23c. NAME OF CEMETERY OR CREMATORY <u>WAKENDA CEM.</u> | 23d. LOCATION (City, town, or county) (State) <u>RAY COUNTY, Mo.</u> |
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| 24. FUNERAL DIRECTOR ADDRESS <u>KRIEBSCHILD & BORNBERG - HARDIN, Mo.</u> | 25. DATE RECD. BY LOCAL REG. <u>2-10-1959</u> | 26. REGISTRAR'S SIGNATURE <u>Malcol Jackson</u> |
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(Licensed Embalmer's Statement on Reverse Side)

All diseases in Part I must be causally related.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

7/1/10

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 *August Bouchard*

Licensed Embalmer No. *4678*

P. O. Address *Hastings, 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.