

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

59-008303
STATE FILE NUMBER

FILED APR 8 1959

Registration District No. 4

Primary Registration District No.

Registrar's No. 35

300
1-57

All diseases in Part I must be causally related.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

1. PLACE OF DEATH a. COUNTY Atchison		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY Atchison	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Rock Port.		c. CITY OR TOWN Rock Port.	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION None		d. STREET ADDRESS (If outside, give location) None	
3. NAME OF DECEASED (Type or print) First Laura Middle Ellen Last Uppike		4. DATE OF DEATH Month 3 Day 29 Year 59	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> 2 DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 3-2-1867
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housekeeper		10b. KIND OF BUSINESS OR INDUSTRY Own Home	11. BIRTHPLACE (City and state or country) Greenville, Tenn., US
13a. FATHER'S NAME Wm McGoy		13b. MOTHER'S MAIDEN NAME Ruth McMurtry	14. NAME OF HUSBAND OR WIFE Chas. Dec.)
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no none		16. SOCIAL SECURITY NO. none	17. INFORMANT Address Blodys Uppike Rock Port, 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) Septicemia DUE TO (b) Aplastic Anemia DUE TO (c) 2924 PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) Generalized Arterio-Sclerosis			INTERVAL BETWEEN ONSET AND DEATH 3 days 3 Months.
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. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
20e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		20f. CITY, TOWN, OR LOCATION COUNTY STATE	
21. I attended the deceased from Dec. 1957 to March, 1959 and last saw her ^{alive} on 3-29-59 Death occurred at 3:15 P. M. on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Daguer or title) James R. Allan, M.D.		22b. ADDRESS Rock Port, Mo	
22c. DATE SIGNED 3-30-59			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 3-31-1959	23c. NAME OF CEMETERY OR CREMATORY High Creek, Cem., Watson, Mo.
24. FUNERAL DIRECTOR Bartholomew Mortuary, Rock Port.		25. DATE RECD. BY LOCAL REG. Mar 31, 1959	26. REGISTRAR'S SIGNATURE Therwin N. Scheeler

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 *Gert Christensen*

Licensed Embalmer No. 3173

P. O. Address Rock Port 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.