

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

59-008999
STATE FILE NUMBER

FILED MAR 30 1959 Registration District No. 120 Primary Registration District No. Registrar's No. 24

1. PLACE OF DEATH a. COUNTY <u>Gentry</u>			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Gentry</u>		
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Albany</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <u>McCall</u>		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF HOSPITAL OR INSTITUTION <u>Gentry County Memorial Hosp.</u>		Length of stay in 1b <u>10 days</u>	d. STREET ADDRESS (If outside, give location)		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <u>Vira</u> Middle <u>Eva</u> Last <u>Fanning</u>			4. DATE OF DEATH Month <u>March</u> Day <u>19</u> Year <u>1959</u>		
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> 2 DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>March, 25, 1890</u>	9. AGE (In years last birthday) <u>68</u>	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>at home</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>at home</u>	11. BIRTHPLACE (City and state or country) <u>Harrison Co. Missouri</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>
13. FATHER'S NAME <u>George H. Rhodes</u>			14. MOTHER'S MAIDEN NAME <u>Sarah E. Day</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>493-14-5060</u>	17. INFORMANT Address <u>Mrs. Mae Swanson, Walthill, Neb.</u>		
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>Cc. Rectum</u>					INTERVAL BETWEEN ONSET AND DEATH <u>1 1/2 years</u>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <u>Metastases to liver etc.</u>					<u>3 mos.</u>
DUE TO (c) _____					<u>154X</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					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 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.)	20f. CITY, TOWN, OR LOCATION <u>Albany, Gentry, Mo.</u>		COUNTY STATE
21. I attended the deceased from <u>1 1/2 years</u> to <u>3-18-59</u> and last saw her alive on <u>3-18-59</u> Death occurred at <u>5:40 a. m.</u> on the date stated above; and to the best of my knowledge, from the causes stated.					
22a. SIGNATURE (Degree or title) <u>Frank H. Rose, M.D.</u>			22b. ADDRESS <u>Albany, Mo.</u>		22c. DATE SIGNED <u>3-20-59</u>
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>burial</u>	23b. DATE <u>Mar. 21, 1959</u>	23c. NAME OF CEMETERY OR CREMATORY <u>McCall</u>		23d. LOCATION (City, town, or county) (State) <u>McCall Missouri</u>	
24. FUNERAL DIRECTOR <u>Clifford Brooks Albany, Mo.</u>			25. DATE RECD. BY LOCAL REG. <u>3-23-59</u>	26. REGISTRAR'S SIGNATURE <u>Mrs. L. W. Bare</u>	

death, welfare, public service, 000-56, diseases in Part I must be causally related. Coroner cannot certify to a death due to natural causes.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

Dr. Frank H. Rose

MEDICAL CERTIFICATION

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was ex-
by me, or by *me*, Student Embalmer No.....
working under my personal supervision..

Student.....
Signature of Student Embalmer

Signed *Donald E. Cochely*

Licensed Embalmer No..... 48

P. O. Address *Albany*.....

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING.
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.