

Health,  
Welfare  
Public  
Service

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

5548-59-009213  
STATE FILE NUMBER  
4718 Registrar's No. 5

Registration District No. 382 Primary Registration District No. \_\_\_\_\_

1. PLACE OF DEATH a. COUNTY <b>Howard</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Missouri</b> b. COUNTY <b>Howard</b>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>Glasgow, Missouri</b>		c. CITY OR TOWN <b>Glasgow</b>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>R.R. Prairie Twp</b>		d. STREET ADDRESS (If outside, give location) <b>R.R. 2 Prairie Twp</b>	
Length of stay in lb <b>45 yrs</b>		Reside on Farm Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	

3. NAME OF DECEASED (Type or print) First <b>JAMES</b> Middle <b>NATHANIEL</b> Last <b>SUTHERLAND</b>			4. DATE OF DEATH Month <b>MAR.</b> Day <b>14,</b> Year <b>1959</b>		
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Oct. 22, 1893</b>	9. AGE (In years last birthday) <b>65</b>	IF UNDER 1 YEAR Months _____ Days _____
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Farming</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Self Employed</b>	11. BIRTHPLACE (City and state or country) <b>Howard County, Mo.</b>	12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	

13a. FATHER'S NAME <b>Nathaniel Sutherland</b>	13b. MOTHER'S MAIDEN NAME <b>Sarah Elizabeth Collins</b>	14. NAME OF HUSBAND OR WIFE <b>Mary Clay Gibbs.</b>
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No.</b>	16. SOCIAL SECURITY NO. <b>489-42-6980</b>	17. INFORMANT Address <b>Mrs James N. Sutherland, Glasgow, Mo.</b>

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary Thrombosis</b>		INTERVAL BETWEEN ONSET AND DEATH <b>Immediate</b>
DUE TO (b) <b>Arteriosclerosis</b>		
DUE TO (c) _____		<b>5 yrs?</b>
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.) <b>4201</b>
20c. TIME OF INJURY Hour _____ 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 <b>Fayette, Missouri</b>
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21. I attended the deceased from **3-14-59** to **3-14-59** and last saw her **dead** him **alive on** **3-14-59**  
Death occurred at **6:00 A** m on the date stated above; and to the best of my knowledge, from the causes stated.

22a. SIGNATURE <b>W. Bloom</b>	(Degree or title)	22b. ADDRESS <b>Fayette, Mo.</b>	22c. DATE SIGNED <b>3-14-59</b>
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23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Removal</b>	23b. DATE <b>3/14/1959</b>	23c. NAME OF CEMETERY OR CREMATORY <b>City Cemetery</b>	23d. LOCATION (City, town, or county) (State) <b>Fayette, Missouri</b>
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24. FUNERAL DIRECTOR <b>Ralph A. Carr</b>	ADDRESS <b>Fayette, Mo.</b>	25. DATE RECD. BY LOCAL REG. <b>Mar. 18, 1959</b>	26. REGISTRAR'S SIGNATURE <b>Walker Audsley</b>
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(Licensed Embalmer's Statement on Reverse Side)

vector, coroner, etc. must use only standard nomenclature in reporting to symptoms with the following: All diseases in Part I must be causally related.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE  
MEDICAL CERTIFICATION

300  
1-57

FILED APR 1 1959

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 *Ralph A. Carr* .....

Licensed Embalmer No. *3340* .....  
P. O. Address *Fayette, 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.