

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

59-010469
STATE FILE NUMBER

FILED MAR 31 1959

Registration District No. 282 Primary Registration District No. _____ Registrar's No. 38

300
1-57 4

1. PLACE OF DEATH a. COUNTY <u>Polk</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Mo</u> b. COUNTY <u>Da de</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Bolivar Mo rtl</u>		c. CITY OR TOWN <u>Greenfield Mo</u>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>Present View Nursing Home</u>		d. STREET ADDRESS (If outside, give location) <u>OWKS</u>	

3. NAME OF DECEASED (Type or print) First <u>Martha</u> Middle <u>V</u> Last <u>Milligan</u>			4. DATE OF DEATH Month <u>Mar</u> Day <u>22</u> Year <u>1959</u>		
---	--	--	---	--	--

5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</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>May 3 1876</u>	9. AGE (In years last birthday) <u>82</u>	10. FUNDER 1 YEAR Months <u>10</u> Days <u>19</u> Hours _____ Min. _____	11. IF UNDER 24 HRS.
----------------------	-------------------------------	---	---------------------------------------	--	---	----------------------

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Nursing</u>	10b. KIND OF BUSINESS OR INDUSTRY <u>Old Folks Home</u>	11. BIRTHPLACE (City and state or country) <u>Virginia</u>	12. CITIZEN OF WHAT COUNTRY? <u>usa</u>
---	--	---	--

13a. FATHER'S NAME <u>Unknown</u>	13b. MOTHER'S MAIDEN NAME <u>unknown</u>	14. NAME OF HUSBAND OR WIFE <u>unknown</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>none</u>	17. INFORMANT <u>Walter Mullins Pineville Virg.</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>acute heart failure</u>		INTERVAL BETWEEN ONSET AND DEATH <u>4 days</u>
DUE TO (b) <u>Chronic myocarditis</u>		
DUE TO (c) <u>4222</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 _____ 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 <u>Greenfield Mo</u>	COUNTY <u>Dade Co</u>	STATE <u>Mo</u>
---	---	--	--	--------------------------	--------------------

21. I attended the deceased from <u>March 18 1959</u> to <u>March 22 1959</u> and last saw her alive on <u>March 18 59</u> Death occurred at <u>11:10 am</u> on the date stated above; and to the best of my knowledge, from the causes stated.
--

22a. SIGNATURE <u>W. R. Allison</u> (Degree or title)	22b. ADDRESS <u>Bolivar Mo</u>	22c. DATE SIGNED <u>3/24/59</u>
--	-----------------------------------	------------------------------------

23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE <u>Mar 24 1959</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Collins</u>	23d. LOCATION (City, town, or county) (State) <u>Dade Co Mo.</u>
--	---------------------------------	--	---

24. FUNERAL DIRECTOR <u>W.R. Allison</u>	ADDRESS <u>Greenfield Mo.</u>	25. DATE RECD. BY LOCAL REG. <u>March 28, 1959</u>	26. REGISTRAR'S SIGNATURE <u>Ralph Gordon Jewell</u>
---	----------------------------------	---	---

All diseases in Part I must be causally related.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

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 *W.R. Allison*

Licensed Embalmer No. *4407*

P. O. Address *Greenfield, N.H.*

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.