

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

59-010542

STATE FILE NUMBER

MAR 17 1959

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

1. PLACE OF DEATH a. COUNTY Ray		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY Ray	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Fishing River		Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	c. CITY OR TOWN RR #1, Orrick 0890
c. FULL NAME OF (IF NOT in hospital, give location) HOSPITAL OR INSTITUTION 1 mile North Orrick		Length of stay in 1b years	d. STREET ADDRESS (If outside, give location) 1 mile North Orrick, Mo
		Reside on Farm Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	

3. NAME OF DECEASED (Type or print) First Emma Middle Olive Last Gaines			4. DATE OF DEATH Month March Day 10 Year 1959		
5. SEX female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH April 26, 1883	9. AGE (In years last birthday) 75	IF UNDER 1 YEAR Months _____ Days _____
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Home	11. BIRTHPLACE (City and state or country) Ray County, Mo		12. CITIZEN OF WHAT COUNTRY? U.S.A.

13a. FATHER'S NAME Joseph Meyers	13b. MOTHER'S MAIDEN NAME Henrietta M Webber	14. NAME OF HUSBAND OR WIFE Charles Gaines
--	--	--

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no	16. SOCIAL SECURITY NO. none	17. INFORMANT Address Mrs Emmett Frank, RR #1, Orrick, 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) Cerebral Thrombosis		INTERVAL BETWEEN ONSET AND DEATH 10 days year
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) Arteriosclerosis	
	DUE TO (c) _____	
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"/> 2

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 COUNTY _____ STATE _____
--	--	--

21. I attended the deceased from **1-3-55** to **3/10/59** and last saw her alive on **3/7/59**.
Death occurred at **12:30** p.m. on the date stated above; and to the best of my knowledge, from the causes stated.

22a. SIGNATURE Raymond Johnson MD	(Degree or title)	22b. ADDRESS 116 State St. Excelsior Springs Mo	22c. DATE SIGNED
---	-------------------	---	------------------

23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE 3-12-59	23c. NAME OF CEMETERY OR CREMATORY Odell	23d. LOCATION (City, town, or county) (State) Excelsior Springs, Mo
--	-----------------------------	--	---

24. FUNERAL DIRECTOR Richard Funeral Home, Inc. Excelsior Springs, Missouri	25. DATE RECD. BY LOCAL REG. 3-17-59	26. REGISTRAR'S SIGNATURE Thomas C. ...
---	--	---

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

All diseases in Part I must be causally related.

62-12158

APR 10 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 *Lundell Jarman*

Licensed Embalmer No. *4589*
Coulters Springs, N.C.
P. O. Address

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.