

Health, Welfare
Public Service

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

59-012084
STATE FILE NUMBER

FILED MAR 31 1959

Registration District No. 360 Primary Registration District No. 6225 Registrar's No. 50

300
-57
2

1. PLACE OF DEATH a. COUNTY <u>VERNON</u>			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MISSOURI</u> b. COUNTY <u>BARRY</u>		
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>WASHINGTON TOWNSHIP</u>		Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	c. CITY OR TOWN <u>SELIGMAN 0050</u>		Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>STATE HOSP. # 3 NEVADA, MO.</u>		Length of stay in 1b <u>2 yrs 14 days</u>	d. STREET ADDRESS (If outside, give location) <u>- - -</u>		Reside on Farm Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <u>AILEY</u> Middle <u>RUSSELL</u> Last <u>AMOS</u>			4. DATE OF DEATH Month <u>MARCH</u> Day <u>26</u> Year <u>1959</u>		
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>NOV. 28. 1878</u>		9. AGE (in years last birthday) <u>80 yrs</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>FARMER</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>	11. BIRTHPLACE (City and state or country) <u>WEST VIRGINIA</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>
13a. FATHER'S NAME <u>AMOS AMOS</u>		13b. MOTHER'S MAIDEN NAME <u>UNKNOWN</u>		14. NAME OF HUSBAND OR WIFE <u>ROSA LEE AMOS</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>UNKNOWN</u>		16. SOCIAL SECURITY NO. <u>- - -</u>	17. INFORMANT Address <u>HOSP. RECORDS STATE HOSP. # 3 NEVADA, MO</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>CORONARY OCCLUSION</u>					INTERVAL BETWEEN ONSET AND DEATH <u>7 HOURS</u>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <u>GENERALIZED ARTERIO SCLEROSIS</u>					<u>MANY YEARS</u>
DUE TO (c) <u>4201</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.) <u>- - -</u>			
20c. TIME OF INJURY Hour <u>-</u> Month <u>-</u> Day <u>-</u> Year <u>-</u> a.m. <u>-</u> p.m. <u>-</u>					
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.) <u>- - -</u>		20f. CITY, TOWN, OR LOCATION COUNTY STATE <u>- - -</u>	
21. I attended the deceased from <u>MARCH 12. 1957</u> to <u>MARCH 26. 1959</u> and last saw <u>him</u> alive on <u>MARCH 26. 1959</u> Death occurred at <u>1:50 A.M.</u> m on the date stated above; and to the best of my knowledge, from the causes stated.					
22a. SIGNATURE (Degree or title) <u>George Esker M.D.</u>			22b. ADDRESS <u>State Hospital # 3</u>		22c. DATE SIGNED <u>3-26-1959</u>
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>March 28-1959</u>		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY <u>Roller Cemetery</u>	
				23d. LOCATION (City, town, or county) (State) <u>Saturday Ark.</u>	
24. FUNERAL DIRECTOR <u>Ferry Funeral Home, Nevada, Missouri</u>			25. DATE REC'D. BY LOCAL REG. <u>3-28-1959</u>		26. REGISTRAR'S SIGNATURE <u>Amal G. Ferry</u>

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE
MEDICAL CERTIFICATION

All diseases in Part I must be causally related.

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 *L. Douglas Perry*

Licensed Embalmer No. *1960*
P. O. Address *Nevada, 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.