

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

59-012140

STATE FILE NUMBER

Registration District No. 378

Primary Registration District No. 6285

Registrar's No. 12

FILED MAR 23 1959

1-57

1. PLACE OF DEATH a. COUNTY <b>Wright</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Missouri</b> b. COUNTY <b>Wright</b>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>Norwood</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <b>Norwood</b> <b>1140</b> 0
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>Route 1</b>		Length of stay in lb <b>61 yrs</b>	d. STREET ADDRESS (If outside, give location) <b>Route 1</b>
			Reside on Form Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print) First <b>Jessie</b> Middle <b>L.</b> Last <b>Claxton</b>			4. DATE OF DEATH Month <b>March</b> Day <b>9</b> Year <b>1959</b>	
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5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> 2 DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>May 8, 1875</b>	9. AGE (In years last birthday) <b>83</b>	10. UNDER 1 YEAR Months <b>0</b> Days <b>0</b>	11. UNDER 24 HRS. Hours <b>0</b> Min. <b>0</b>
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and state or county) <b>Durango County, Iowa</b>	12. CITIZEN OF WHAT COUNTRY? <b>USA</b>
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13a. FATHER'S NAME <b>Marcellus Allen</b>	13b. MOTHER'S MAIDEN NAME <b>Martha Mary Wells</b>	14. NAME OF HUSBAND OR WIFE <b>James Claxton</b>
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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.	17. INFORMANT <b>Mrs Stella Jones - Norwood, Missouri</b>
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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>Decompensated Cor Pulmonale</b>		INTERVAL BETWEEN ONSET AND DEATH <b>1 Day</b>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) <b>Pulmonary Corrosification</b>	<b>3 Days</b>
	DUE TO (c) <b>Unresolved Pulmonary Lobar Pneumonia</b>	<b>5 days</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <b>Arteriosclerosis</b>		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.)
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20c. TIME OF INJURY Hour <b>5:15 A.</b> Month, Day, Year	20d. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	20e. CITY, TOWN, OR LOCATION <b>Norwood</b>	COUNTY <b>Wright</b>	STATE <b>Mo</b>
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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 <b>Norwood</b>	COUNTY <b>Wright</b>	STATE <b>Mo</b>
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21. I attended the deceased from <b>March 3, 1959</b> , to <b>March 9, '59</b> and last saw her <sup>her</sup> <sub>him</sub> alive on <b>March 9, 1959</b> Death occurred at <b>5:15 A.</b> m on the date stated above; and to the best of my knowledge, from the causes stated.
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22a. SIGNATURE <b>Richard L. Mitchell</b> (Degree or title)	22b. ADDRESS <b>DO. Mtn. Grove, Mo</b>	22c. DATE SIGNED <b>3-13-59</b>
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23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE <b>March 11, 1959</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Curtis Cemetery</b>	23d. LOCATION (City, town, or county) (State) <b>Norwood, Wright County, Mo</b>
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24. FUNERAL DIRECTOR <b>Ba rber Funera l Home</b>	ADDRESS <b>Mtn. Grove, Mo</b>	25. DATE RECD. BY LOCAL REG. <b>March 14, 1959</b>	26. REGISTRAR'S SIGNATURE <b>Genevieve L. Silverman</b>
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USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed. All diseases in Part I must be causally related.

Date Recd 3-20-07

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 *George Stepp* .....

Licensed Embalmer No. *3161* .....

P. O. Address *11111 1st St, New York, NY* .....

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.