

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

59-012747

STATE FILE NUMBER

FILED MAY 11 1959

Registration District No. 77 Primary Registration District No. 3016 Registrar's No. 134

300
1-57

1. PLACE OF DEATH a. COUNTY Cole		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY Cole	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Jefferson City		c. CITY OR TOWN Jefferson City,	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Chas E. Still Hospital		d. STREET ADDRESS (If outside, give location) 610 State St.	
3. NAME OF DECEASED (Type or print) First Middle Last LYDIE ELVIRA PERCIVAL			4. DATE OF DEATH Month Day Year May- 3- 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 Oct. 12-1906
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House Maid		10b. KIND OF BUSINESS OR INDUSTRY	9. AGE (In years) 1st birthday 58
11. BIRTHPLACE (City and state or country) Linn Creek, Mo.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13a. FATHER'S NAME Wesley Scott		13b. MOTHER'S MAIDEN NAME Rose Leffert	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		17. INFORMANT Address Mrs. Ann Huddleston Jefferson City 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) Respiratory Failure Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. } DUE TO (b) Pulmonary embolism DUE TO (c) Fractured R. Hip 9040			INTERVAL BETWEEN ONSET AND DEATH
20a. ACCIDENT <input checked="" 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.) Fell in home	
20c. TIME OF INJURY Hour Month, Day, Year a.m. 4-9-59 p.m.		20d. INJURY OCCURRED WHILE AT <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/> 20e. PLACE OF INJURY (e.g., in or about home, firm, factory, street, office bldg., etc.) In home	
21. I attended the deceased from 4-9-59 to 5-3-59 and last saw her alive on 5-3-59 Death occurred at 3:50 a.m. on the date stated above; and to the best of my knowledge, from the causes stated.		22a. SIGNATURE (Degree or title) R. C. Michael Sr.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 5-6-1959	
23c. NAME OF CEMETERY OR CREMATORY Freedom Cem.		23d. LOCATION (City, town, or county) (State) Linn Creek Mo.	
24. FUNERAL DIRECTOR W. Steffen-Russell		26. REGISTRAR'S SIGNATURE R. P. Norris, MD MR.	

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

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.

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 *R. Hoffmann*

Licensed Embalmer No. *2307*
P. O. Address *Russell*

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.