

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

59-012784

STATE FILE NUMBER

FILED MAY 5 1959 Registration District No. 096 Primary Registration District No. Registrar's No. 23

300  
1-57

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

1. PLACE OF DEATH a. COUNTY Dallas		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Mo. b. COUNTY Dallas	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Sherman		c. CITY OR TOWN Sherman Township 0.309	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Tunas, Mo.		d. STREET ADDRESS (If outside, give location) Tunas, Mo.	
3. NAME OF DECEASED (Type or print) First Middle Last Martha Cornelia Ethridge		4. DATE OF DEATH Month Day Year April 26, 1959	
5. SEX Female	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Feb. 24, 1889m
9a. AGE (In years last birthday) 72	9b. IF UNDER 1 YEAR Months 2 Days 2	9c. IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and state or country) Dallas	12. CITIZEN OF WHAT COUNTRY? U.S.
13a. FATHER'S NAME H.J. Tucker	13b. MOTHER'S MAIDEN NAME Laura Vandlandingham	14. NAME OF HUSBAND OR WIFE W.D. Ethridge	
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 W.D. Ethridge Tunas, Mo. 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) Cerebral hemorrhage Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) Essential hypertension DUE TO (c) Atherosclerosis PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)			INTERVAL BETWEEN ONSET AND DEATH 1 hour
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.) 331X		
20c. TIME OF INJURY Hour Month, Day, Year 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	COUNTY STATE
21. I attended the deceased from 4/18/59 to 4/26/59 and last saw her alive on 4/24/59 Death occurred at 6:00 AM m on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE Joseph A. Bennett, D. O.	22b. ADDRESS Buffalo, Missouri	22c. DATE SIGNED 4/27/59	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE April 28/59	23c. NAME OF CEMETERY OR CREMATORY Hopewell Cemetery	23d. LOCATION (City, town, or county) (State) Dallas County, Mo.
24. FUNERAL DIRECTOR Montgomery Funeral Home Buffalo, Mo.	ADDRESS	25. DATE RECD. BY LOCAL REG. 5/4/59	26. REGISTRAR'S SIGNATURE Mrs Vera Petree

**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 *Clyde Montgomery* .....  
Licensed Embalmer No. *3592* .....  
P. O. Address *Buffalo, N.Y.* .....

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.