

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

59-013115
STATE FILE NUMBER

FILED APR 21 1959

Registration District No. 141 Primary Registration District No. 3025 Registrar's No. 38

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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.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE
MEDICAL CERTIFICATION

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|--|------------------------------|---|---|
| 1. PLACE OF DEATH a. COUNTY <u>Worcell</u> | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Worcell</u> | |
| b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>West Plains</u> | | Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> | c. CITY OR TOWN <u>West Plains</u> 461 Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/> |
| c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>Memorial Hosp</u> | | Length of stay in 1b <u>12 hrs</u> | d. STREET ADDRESS (If outside, give location) <u>413 Summers</u> |
| 3. NAME OF DECEASED (Type or print) First Middle Last <u>Arthur A. Achuff</u> | | | 4. DATE OF DEATH Month Day Year <u>3-31-1959</u> |
| 5. SEX <u>m</u> | 6. COLOR OR RACE <u>w</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>7-7-1880</u> |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Printer</u> | | 10b. KIND OF BUSINESS OR INDUSTRY <u>✓</u> | 11. BIRTHPLACE (City and state or country) <u>Yinton Iowa</u> |
| 12. CITIZEN OF WHAT COUNTRY? <u>USA</u> | | 13a. FATHER'S NAME <u>W. G. Achuff</u> | |
| 13b. MOTHER'S MAIDEN NAME <u>Anna Bloeborn</u> | | 14. NAME OF HUSBAND OR WIFE <u>✓</u> | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>Yes</u> | | 16. SOCIAL SECURITY NO. <u>5410</u> | 17. INFORMANT <u>Anna Nichols West Plains 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>GASTRIC HEMORRHAGE</u> DUE TO (b) <u>DUODENAL ULCER</u> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. } DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>SENILITY - ARTERIOSCLEROSIS - 5410</u> | | | INTERVAL BETWEEN ONSET AND DEATH <u>2 DAYS</u> <u>1 YEAR</u> |
| 20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input checked="" 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 a.m. 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>July 15, 1958</u> and last saw him alive on <u>MARCH 31, 1959</u> Death occurred at <u>6:45 A.M.</u> on the date stated above, and to the best of my knowledge, from the causes stated. | | | |
| 22a. SIGNATURE (Doctor or title) <u>Jack N. Wilson, M.D. West Plains, Mo.</u> | | 22b. ADDRESS <u>No. 4-7-59</u> | |
| 22c. DATE SIGNED <u>4-7-59</u> | | 23a. NAME OF CEMETERY OR CREMATORY <u>West Plains, Mo</u> | |
| 23b. LOCATION (City, town, or county) (State) <u>West Plains, Mo</u> | | 23c. DATE <u>4-3-1959</u> | |
| 24. FUNERAL DIRECTOR <u>Robertson's West Plains Mo</u> | | 25. DATE RECD. BY LOCAL REG. <u>4-17-59</u> | |
| 26. REGISTRAR'S SIGNATURE <u>Beatrice Cook</u> | | | |

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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 *A. S. Robert*

Licensed Embalmer No. *3437*
P. O. Address *West Plains*

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.