

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

59-013829

STATE FILE NUMBER

FILED APR 29 1959 Registration District No. 160 Primary Registration District No. 3030 Registrar's No. 64

5. 300
1-57

1. PLACE OF DEATH a. COUNTY JEFFERSON		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MISSOURI b. COUNTY JEFF.	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN FESTUS		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN FESTUS Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION 311 Lee Ave.		Length of stay in 1b	d. STREET ADDRESS (If outside, give location) 311 LEE, AVE. Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Middle Last DESSIE MAE RAMSEY			4. DATE OF DEATH Month Day Year 4-24-59
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 1-17-1891
9. AGE (In years last birthday) 68		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSE WORK OWN HOME	11. BIRTHPLACE (City and state or country) WHITE WATER, MO.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSE WORK OWN HOME		10b. KIND OF BUSINESS OR INDUSTRY *** ** *	12. CITIZENSHIP OF WHAT COUNTRY? USA
13a. FATHER'S NAME JOSEPH C. EAKINS		13b. MOTHER'S MAIDEN NAME BARBARA L. KENION	14. NAME OF HUSBAND OR WIFE ***
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	17. INFORMANT MRS TOM HAGAN Address FESTUS, 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) Cerebral Hemorrhage Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. } DUE TO (b) Hypertension & arteriosclerosis DUE TO (c) _____ 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 6 hrs 5 yr
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.		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20d. INJURY OCCURRED WHILE AT WORK <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 Death occurred at 5:00 4/19/59 to 4/24/59 and last saw her 4/24/59 alive on 4/24/59 m on the date stated above; and to the best of my knowledge, from the causes stated.		21. I attended the deceased from Death occurred at 5:00 4/19/59 to 4/24/59 and last saw her 4/24/59 alive on 4/24/59 m on the date stated above; and to the best of my knowledge, from the causes stated.	
22a. SIGNATURE <i>[Signature]</i>		22b. ADDRESS MO	22c. DATE SIGNED 4/25/59
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE 4-27-59	23c. NAME OF CEMETERY OR CREMATORY DOE RUN, MO.
24. FUNERAL DIRECTOR GENTRY R. POLITTE		25. DATE RECD. BY LOCAL REG. 4/25/59	26. REGISTRAR'S SIGNATURE <i>[Signature]</i>
ADDRESS CRYSTAL CITY, MO.			

All diseases in Part I must be causally related.

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.

DATE RECEIVED
APR 28 1959

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 *Gentry R. Polittle*

Licensed Embalmer No. *3481*

P. O. Address *Crystal City*

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.