Health, Welfare Public Service

300 -57 4

THE DIVISION OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

59-014042

STATE FILE NUMBER

FILED APR 27 1959 Registration District No. 385 Primary Registration District No. 3039 Registrar's No. 35

1. PLACE OF DEATH
a. COUNTY LINN
b. CITY OR TOWN (If outside corporate limits, give TOWNSHIP only) MARCELINE — Inside Limits Yes [X] No [ ]
c. FULL NAME OF HOSPITAL OR INSTITUTION (If NOT in hospital, give location) BUNTON'S RE.T HOME — Length of stay in 1b 6YRS

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE MO b. COUNTY LINN
c. CITY OR TOWN MARCELINE, 0581 — Inside Limits Yes [X] No [ ]
d. STREET ADDRESS (If outside, give location) — Reside on Farm Yes [ ] No [ ]

3. NAME OF DECEASED (Type or print) First NELLIE Middle Last REIMER

4. DATE OF DEATH Month 4 Day 10 Year 1959

5. SEX F 6. COLOR OR RACE W 7. MARRIED [ ] NEVER MARRIED [ ] WIDOWED [X] DIVORCED [ ] 8. DATE OF BIRTH UNKNOWN 9. AGE (In years last birthday) UNKNOWN IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) UNKNOWN 10b. KIND OF BUSINESS OR INDUSTRY 11. BIRTHPLACE (City and state or country) UNKNOWN 12. CITIZEN OF WHAT COUNTRY?

13a. FATHER'S NAME UNKNOWN 13b. MOTHER'S MAIDEN NAME UNKNOWN 14. NAME OF HUSBAND OR WIFE UNKNOWN

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 NONE Address

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) INTERVAL BETWEEN ONSET AND DEATH

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Cerebral Thrombosis, Multiple
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) Arteriosclerotic Hypertensive
DUE TO (c) Cardio Vascular Disease

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) 443X

19. WAS AUTOPSY PERFORMED? YES [ ] NO [ ]

20a. ACCIDENT [ ] SUICIDE [ ] HOMICIDE [ ] 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)

20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year

20d. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ] 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 1953, to 4-10-59 and last saw her/him alive on
Death occurred at 6:00 p.m. on the date stated above; and to the best of my knowledge, from the causes stated.

22a. SIGNATURE [signature] (Degree or title) MD 22b. ADDRESS MARCELINE, MO. 22c. DATE SIGNED 4-13-59

23a. BURIAL, CREMATION, REMOVAL (Specify) B 23b. DATE 4/12/59 23c. NAME OF CEMETERY OR CREMATORY MT. OLIVET 23d. LOCATION (City, town, or county) MARCELINE, (State) MO.

24. FUNERAL DIRECTOR JAMES MCLAUGHLIN ADDRESS MARCELINE, MO 25. DATE RECD. BY LOCAL REG. 4-13-59 26. REGISTRAR'S SIGNATURE Brookie Owens

(Licensed Embalmer's Statement on Reverse Side)

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

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 James B. McClelland

Licensed Embalmer No. H230

P. O. Address Brookfield, Mo

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.