

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

59-014060

STATE FILE NUMBER

APR 17 1959

Registration District No. 187 Primary Registration District No. 3040 Registrar's No. 107

S. 300  
1-57

1. PLACE OF DEATH a. COUNTY Livingston				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY Sullivan			
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Chillicothe			Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN Green Castle		Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
c. FULL NAME OF (IF NOT in hospital, give location) HOSPITAL OR INSTITUTION City Hospital			Length of stay in 1b 7 days	d. STREET ADDRESS (If outside, give location) 2 mi. W. Green Castle		Reside on Farm Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last Nannie ----- Muir				4. DATE OF DEATH Month Day Year April 11, 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 Nov. 6, 1883		9. AGE (In years last birthday) 75	IF UNDER 1 YEAR Months Days 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 Farm Home	11. BIRTHPLACE (City and state or country) Brookfield, Mo.		12. CITIZEN OF WHAT COUNTRY? USA		
13a. FATHER'S NAME Charles Allen		13b. MOTHER'S MAIDEN NAME Cynthia Carlton		14. NAME OF HUSBAND OR WIFE Arthur Muir			
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. Don't know	17. INFORMANT Address Mrs. Arthur Capps, Tina, 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) <i>Cerebral Embolus</i>						INTERVAL BETWEEN ONSET AND DEATH <i>5 days</i>	
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. } DUE TO (b) _____ DUE TO (c) _____							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
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.)					
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 <i>Apr. 8-59</i> to <i>Apr. 11-59</i> and last saw her alive on <i>Apr. 11-59</i> Death occurred at <i>945A</i> m on the date stated above; and to the best of my knowledge, from the causes stated.							
22a. SIGNATURE (Degree or title) <i>Joseph A. Conrad M.D.</i>				22b. ADDRESS <i>Chillicothe, Mo.</i>		22c. DATE SIGNED <i>April-59</i>	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE 4/13/1959	23c. NAME OF CEMETERY OR CREMATORY Green Castle Cemetery		23d. LOCATION (City, town, or county) (State) Green Castle, M.			
24. FUNERAL DIRECTOR <i>Alvan E. Kent &amp; Son, Green City, Mo.</i>			25. DATE RECD. BY LOCAL REG. 4/11/59		26. REGISTRAR'S SIGNATURE <i>Frances B Neall</i>		

(Licensed Embalmer's Statement on Reverse Side)

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

SEP 23 1959

MAY 1 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 *Karl R. Kent* .....

Licensed Embalmer No. *4689* .....

P. O. Address *Green City, 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.