

Health,  
& Welfare  
Public  
Service

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

59-014109  
STATE FILE NUMBER

FILED MAY 14 1959

Registration District No. 209 Primary Registration District No. 3043 Registrar's No. 140

300  
1-57

1. PLACE OF DEATH a. COUNTY <i>Marion</i>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Missouri</i> b. COUNTY <i>Pike</i>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <i>Hannibal</i>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <i>Louisiana</i> <i>0826</i>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <i>Levering Hospital</i>		Length of stay in 1b <i>24 hours</i>	d. STREET ADDRESS (If outside, give location) <i>Highway 29 North</i>
Reside on Form Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>			

3. NAME OF DECEASED (Type or print) First Middle Last <i>RUBY EDNA BETTS.</i>			4. DATE OF DEATH Month Day Year <i>May 9, 1959</i>		
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5. SEX <i>Female</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>Feb. 9, 1894</i>	9. AGE (In years) (If UNDER 1 YEAR IF UNDER 24 HRS. Last birthday) Months Days Hours Min. <i>65</i>	
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>housewife</i>	10b. KIND OF BUSINESS OR INDUSTRY <i>at home</i>	11. BIRTHPLACE (City and state or country) <i>Missouri</i>	12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>
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13a. FATHER'S NAME <i>James M Davis</i>	13b. MOTHER'S MAIDEN NAME <i>Caroline Browning</i>	14. NAME OF HUSBAND OR WIFE <i>Evert Betts</i>
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15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) <i>No</i>	16. SOCIAL SECURITY NO. <i>No</i>	17. INFORMANT <i>Evert Betts</i> Address <i>Louisiana Mo.</i>
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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>Acute cerebral vascular accident</i>		INTERVAL BETWEEN ONSET AND DEATH <i>one day</i>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) <i>Diabetes mellitus</i>	
	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.)
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20c. TIME OF INJURY Hour Month, Day, Year a.m. p.m.
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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
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21. I attended the deceased from <i>May 8, 1959</i> to <i>May 9, 1959</i> and last saw her alive on <i>May 9, 1959</i> Death occurred at <i>Seven</i> P m on the date stated above; and to the best of my knowledge, from the causes stated.
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22a. SIGNATURE (Degree or title) <i>In Carolla M R</i> M. D.	22b. ADDRESS <i>707 Bdw, Hannibal, Missouri</i>	22c. DATE SIGNED <i>5/9/1959</i>
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23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Removal</i>	23b. DATE <i>May 9, 1959</i>	23c. NAME OF CEMETERY OR CREMATORY <i>Daylor Cemetery</i>	23d. LOCATION (City, town, or county) (State) <i>Rockport, Ill.</i>
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24. FUNERAL DIRECTOR <i>Therese Emeral Home</i> ADDRESS <i>Louisiana Mo</i>	25. DATE RECD. BY LOCAL REG. <i>5/11/59</i>	26. REGISTRAR'S SIGNATURE <i>N E M Lucke By J C Fisher</i>
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(Licensed Embalmer's Statement on Reverse Side)

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

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 *J. B. Sterne* .....

Licensed Embalmer No. *4039* .....

P. O. Address *Louisiana* .....

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.