

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

59-014284
STATE FILE NUMBER

FILED APR 27 1959

Registration District No. 256 Primary Registration District No. 4388 Registrar's No. 3

300
1-57

1. PLACE OF DEATH a. COUNTY <u>Osage</u>			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Osage</u>		
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Chamois</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <u>Chamois</u> <u>0760</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION		Length of stay in 1b <u>70 years</u>	d. STREET ADDRESS (If outside, give location)		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <u>Matthew</u> Middle <u>Circuitt</u> Last <u>Circuitt</u>			4. DATE OF DEATH Month <u>April</u> Day <u>21</u> Year <u>1959</u>		
5. SEX <u>Male</u>	6. COLOR OR RACE <u>Negro</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>June 5, 1871</u>	9. AGE (In years last birthday) <u>87</u> IF UNDER 1 YEAR: Months <u>0</u> Days <u>0</u> IF UNDER 24 HRS.: Hours <u>0</u> Min. <u>0</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>labor</u>		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and state or country) <u>Reform, Mo</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA.</u>
13a. FATHER'S NAME <u>Manulis Circuitt</u>		13b. MOTHER'S MAIDEN NAME <u>Mary Bledsoe</u>		14. NAME OF HUSBAND OR WIFE <u>Mrs. Mason Circuitt</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>NONE</u>	17. INFORMANT Address <u>Mrs. Helen Mills Chamois 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>Coronary Embolism</u>				INTERVAL BETWEEN ONSET AND DEATH <u>5 min.</u>	
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.		DUE TO (b) <u>Hypotension + Generalized arteriosclerosis</u>		DUE TO (c) <u>10 years.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>Virus pneumoniae (4 1/2 months)</u>				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 <u>5:30</u> Month, Day, Year <u>3-3-54</u> 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 <u>Chamois</u>		COUNTY	STATE
21. I attended the deceased from <u>3-3-54</u> to <u>4-21-59</u> and last saw her/him alive on <u>4-18-59</u> . Death occurred at <u>5:30 p</u> m on the date stated above; and to the best of my knowledge, from the causes stated.					
22a. SIGNATURE (Do not use title) <u>F. B. Farnsworth, D.D.</u>			22b. ADDRESS <u>Chamois</u>		22c. DATE SIGNED <u>4/23/59</u>
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE <u>4/26/1959</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Chamois City</u>		23d. LOCATION (City, town, or county) <u>Chamois, Mo</u>
24. FUNERAL DIRECTOR <u>Clyde Morton</u>		ADDRESS <u>Chamois</u>		25. DATE RECD. BY LOCAL REG. <u>April 24, 1959</u>	26. REGISTRAR'S SIGNATURE <u>Josephine Schieder</u>

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

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.

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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 *Vernon M. Morton*.....

Licensed Embalmer No. *4125*.....

P. O. Address *Linn, 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.