

Health,  
& Welfare  
Public  
Service

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

59-016463

STATE FILE NUMBER

FILED APR 30 1959

Registration District No. 340 Primary Registration District No. 6152 Registrar's No. 42

300  
1-57

1. PLACE OF DEATH a. COUNTY <b>Stoddard</b>			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Missouri</b> b. COUNTY <b>Stoddard</b>			
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>Dexter Liberty Twp.</b>		Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	c. CITY OR TOWN <b>Bloomfield</b>		Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
c. FULL NAME OF (IF NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>Green Meadows Rest Home</b>		Length of stay in 1b <b>2 wks.</b>	d. STREET ADDRESS (If outside, give location) <b>Rfd. 2</b>		Reside on Farm Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Althea</b> Middle <b>Crutcher</b> Last <b>Crutcher</b>			4. DATE OF DEATH Month <b>April</b> Day <b>14</b> Year <b>1959</b>			
5. SEX <b>female</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>June 19, 1887</b>	9. AGE (In years last birthday) <b>71</b> 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) <b>housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>housewife</b>	11. BIRTHPLACE (City and state or country) <b>Bloomfield, Mo.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13a. FATHER'S NAME <b>Frank Harty</b>		13b. MOTHER'S MAIDEN NAME <b>Alcie Whitlege</b>		14. NAME OF HUSBAND OR WIFE <b>deceased</b>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>no</b> <b>X X X X X X X X</b>		16. SOCIAL SECURITY NO.	17. INFORMANT Address <b>C. C. Crutcher Bloomfield, Mo. R. 2</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral Hemorrhage</b> DUE TO (b) <b>Generalized Atherosclerosis</b> DUE TO (c) _____ Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <b>Hypertension, severe years.</b>					INTERVAL BETWEEN ONSET AND DEATH <b>2 days</b> <b>years</b>	
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 _____ a.m. _____ p.m. Month, Day, Year _____						
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 <b>Aug 65</b> to <b>April 59</b> and last saw her alive on <b>4-2-59</b> Death occurred at <b>11:00 AM</b> on the date stated above; and to the best of my knowledge, from the causes stated.						
22a. SIGNATURE <b>Althea Crutcher W.D.</b> (Degree or title)			22b. ADDRESS <b>Bloomfield, Mo.</b>		22c. DATE SIGNED <b>4-16-59</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE <b>4-16-59</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Bloomfield cemetery</b>		23d. LOCATION (City, town, or county) (State) <b>Bloomfield, Mo.</b>		
24. FUNERAL DIRECTOR <b>Watkins &amp; Sons</b> ADDRESS <b>Dexter, Mo.</b>		25. DATE RECD. BY LOCAL REG. <b>4/23/59</b>	26. REGISTRAR'S SIGNATURE <b>Velma V. Jenkins</b>			

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

Severely contagious diseases only - and/or communicable diseases - no symptoms will be listed. 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 Mark W. Johnson .....

Licensed Embalmer No. 4217 .....

P. O. Address Dexter 410 .....

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.