

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

59-016478

STATE FILE NUMBER

FILED APR 20 1959

Registration District No. 381 Primary Registration District No. 6183 Registrar's No. 30

300

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1. PLACE OF DEATH a. COUNTY Sullivan		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Mo. b. COUNTY Putnam	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Polk Rural Tmp.		c. CITY OR TOWN Rural-Elm Tmp. 0860	
c. FULL NAME OF (If in institution, give location) HOSPITAL OR INSTITUTION Milan		d. STREET ADDRESS (If outside, give location) Livonia, Mo.	
3. NAME OF DECEASED (Type or print) First Middle Last Martha Alexander		4. DATE OF DEATH Month Day Year Apr. 6, 1959	
5. SEX F	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> 2 DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH July 24, 72
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) home work		11. BIRTHPLACE (City and state or country) Putnam Co., Mo.	12. CITIZEN OF WHAT COUNTRY? U.S.
13a. FATHER'S NAME Jacob Tietsort		13b. MOTHER'S MAIDEN NAME Delila Admire	14. NAME OF HUSBAND OR WIFE James Alexander-dec.
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. none	17. INFORMANT Address James Tietsort-Livonia, Missouri
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Hemorrhage Conditions, if any, which gave rise to above cause (a), starting the underlying cause last. } DUE TO (b) Hypertension DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) _____			INTERVAL BETWEEN ONSET, AND DEATH 12 hrs - 15 yrs -
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 1958 to 4-6-59 and last saw her alive on 4-5-59 Death occurred at 9:20 P.M. on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree or title) E. W. Simpson D.O.		22b. ADDRESS W. L. W.	22c. DATE SIGNED 4-9-59
23a. BURIAL, CREMATION, REMOVAL (Specify) B.	23b. DATE 4-9-59	23c. NAME OF CEMETERY OR CREMATORY Pleasant Home Cem.	23d. LOCATION (City, town, or county) (State) Worthington, Mo.
24. FUNERAL DIRECTOR ADDRESS F.O. Husted & Son -Unionville, Mo.		25. DATE RECD. BY LOCAL REG. 4-9-59	26. REGISTRAR'S SIGNATURE Mrs. M. W. Beckett

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 *Murl E. Husted*

Licensed Embalmer No. *3307*
P. O. Address *Monroville*

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.