

Health, Welfare
Public Service

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

59-1817552
STATE FILE NUMBER

Registration District No. 141 Primary Registration District No. 5554 Registrar's No. 67

1. PLACE OF DEATH a. COUNTY <u>Howell</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Howell</u>	
b. CITY OR TOWN <u>Rollersville</u> If outside corporate limits, give TOWNSHIP only Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>		c. CITY OR TOWN <u>Rollersville</u> Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
c. FULL NAME OF (IF NOT in hospital, give location) HOSPITAL OR INSTITUTION <input checked="" type="checkbox"/>		d. STREET ADDRESS <u>R 7 D</u> If outside, give location Reside on Farm Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	

3. NAME OF DECEASED (Type or print) First Middle Last <u>Rilda Jane Genter</u>			4. DATE OF DEATH Month Day Year <u>5/27-1959</u>		
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>4-7-1894</u>	9. AGE (In years last birthday) <u>64</u>	IF UNDER 1 YEAR Months Days <u>6 20</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Wife</u>		10b. KIND OF BUSINESS OR INDUSTRY <input checked="" type="checkbox"/>	11. BIRTHPLACE (City and state or country) <u>Arva Mo</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>

13a. FATHER'S NAME <u>Marion Crony</u>		13b. MOTHER'S MAIDEN NAME <u>Nancy Kulpis</u>		13c. NAME OF HUSBAND OR WIFE <u>W.C. Genter</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, give war or <u>branches of service</u>)		16. SOCIAL SECURITY NO. <input checked="" type="checkbox"/>		17. INFORMANT <u>W.C. Genter, Rollersville Mo</u> Address:	

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>Cerebral thrombosis</u>		INTERVAL BETWEEN ONSET AND DEATH <u>5 days</u>
DUE TO (b) <u>Cerebral arteriosclerosis</u>		<u>5 years</u>
DUE TO (c) _____		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>Chronic pyelonephritis</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 Month, Day, Year a.m. p.m.			
20d. INJURY OCCURRED WHILE AT WORK <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 5/22/59 to 5/27/59 and last saw her alive on 5/25/59
Death occurred at 12:15 m on the date stated above; and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) <u>W.L. Fowler M.D.</u>	22b. ADDRESS <u>West Plains Mo</u>	22c. DATE SIGNED <u>5/2/59</u>
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23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE <u>5/29-59</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Ball</u>	23d. LOCATION (City, town, or county) (State) <u>Arva Mo</u>
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24. FUNERAL DIRECTOR <u>Robert M. West</u>	ADDRESS <u>West Plains Mo</u>	25. DATE RECD. BY LOCAL REG. <u>6-5-59</u>	26. REGISTRAR'S SIGNATURE <u>Beatrice Cook</u>
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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.

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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 *D. D. Roberts*

Licensed Embalmer No. *3437*
P. O. Address *West Plains*

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.