Health, Welfare Public Service

300
1-57

THE DIVISION OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

59-017559
STATE FILE NUMBER

FILED JUN 15 1959 Registration District No. _____ Primary Registration District No. 5556 Registrar's No. 36

1. PLACE OF DEATH
a. COUNTY Howell County
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Goldsberry — Inside Limits Yes ☐ No ☑
c. FULL NAME OF HOSPITAL OR INSTITUTION (If NOT in hospital, give location) St. Francis Hosp. — Length of stay in 1b

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Missouri b. COUNTY Shannon
c. CITY OR TOWN Jerusita — Inside Limits Yes ☐ No ☑
d. STREET ADDRESS (If outside, give location) — Reside on Farm Yes ☐ No ☑

3. NAME OF DECEASED (Type or print): First Arminta — Middle Jane — Last Reese

4. DATE OF DEATH Month May Day 31 Year 1959

5. SEX Female **6. COLOR OR RACE** White **7. MARRIED** ☐ **NEVER MARRIED** ☐ **WIDOWED** ☑ **DIVORCED** ☐

8. DATE OF BIRTH Oct. 9, 1880 **9. AGE** (In years last birthday) 78 — 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) Housewife
10b. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (City and state or country) Missouri
12. CITIZEN OF WHAT COUNTRY? USA

13a. FATHER'S NAME Joshua Farrar
13b. MOTHER'S MAIDEN NAME Elizabeth Duncan
14. NAME OF HUSBAND OR WIFE

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no (If yes, give war or dates of service)
16. SOCIAL SECURITY NO. none
17. INFORMANT Paul Reese — Address Mountain View, Missouri

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Ventricular fibrillation
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.
DUE TO (b) Arteriosclerotic heart disease
DUE TO (c)
INTERVAL BETWEEN ONSET AND DEATH

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) 4200

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT ☐ **SUICIDE** ☐ **HOMICIDE** ☐
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 WORK ☐ NOT WHILE AT WORK ☐
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 May 28, 1959 to May 31 and last saw her/him alive on May 31, 1959
Death occurred at 1:000 a.m. on the date stated above; and to the best of my knowledge, from the causes stated.

22a. SIGNATURE M. C. Walton M.D. (Degree or title)
22b. ADDRESS Mt. View, Mo.
22c. DATE SIGNED 6-9-59

23a. BURIAL, CREMATION, REMOVAL (Specify) Burial
23b. DATE
23c. NAME OF CEMETERY OR CREMATORY Pilgram Rest
23d. LOCATION (City, town, or county) (State) Mountain View, Missouri

24. FUNERAL DIRECTOR Duncan Funeral Home — **ADDRESS** Mtn. View, Mo.
25. DATE RECD. BY LOCAL REG. 6-12-59
26. REGISTRAR'S SIGNATURE Laura Mitchell

(Licensed Embalmer's Statement on Reverse Side)

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

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 Richard A. Norton

Licensed Embalmer No. 5029

P. O. Address Mt. Vernon

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: