

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

59-018290

STATE FILE NUMBER

FILED MAY 25 1959

Registration District No. 174 Primary Registration District No. 3035 Registrar's No. 50

300
-57

1. PLACE OF DEATH a. COUNTY <u>LAFAYETTE</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>COLORADO</u> b. COUNTY <u>PUEBLO</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Lexington</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <u>PUEBLO</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 <u>Cliff Drive</u>		Length of stay in 1b <u>enroute</u>	305 d. STREET ADDRESS (If outside, give location) <u>2707 E. 7th St.</u> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print) First <u>JAMES</u> Middle <u>RUDOLPH</u> Last <u>ESTES</u>			4. DATE OF DEATH Month <u>MAY</u> Day <u>7</u> Year <u>1959</u>		
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Nov. 28 - 1940</u>		9. AGE (In years last birthday) <u>18</u> IF UNDER 1 YEAR: Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u> IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>NONE</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>none</u>	11. BIRTHPLACE (City and state or country) <u>Walnut Ridge, Ark.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>
13a. FATHER'S NAME <u>James Estes</u>		13b. MOTHER'S MAIDEN NAME <u>AGNES - ??? (unknown)</u>		14. NAME OF HUSBAND OR WIFE <u>NONE</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>521-54-2489</u>		17. INFORMANT <u> Lloyd Cunningham</u> Address <u>Kansas City, 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>Shock</u>		INTERVAL BETWEEN ONSET AND DEATH <u>almost immediate</u>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) <u>Multiple fracture - skull, lower jaw</u>	
	DUE TO (c) <u>Hemorrhage into pleural cavities</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>

20a. ACCIDENT <input checked="" 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.) <u>Motor car in which he was a passenger struck the</u>	
20c. TIME OF INJURY Hour <u>11:30</u> Month <u>5</u> Day <u>9</u> Year <u>59</u> p.m.		World War memorial at junction of 29th & 13th highways	
20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <u>junction 13th & highway</u>	20f. CITY, TOWN, OR LOCATION <u>Lexington</u> COUNTY <u>Lafayette</u> STATE <u>Mo</u>
21. I attended the deceased from <u>after death</u> to <u> </u> and last saw her/him alive on <u>never</u> Death occurred at <u>11:30</u> p. m on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE <u>W. Marchant</u> (Degree or title) <u>Coroner</u> ³		22b. ADDRESS <u>O desc Mo</u>	
22c. DATE SIGNED <u>5-9-59</u>			

23a. BURIAL, CREMATION, REMOVAL (Specify) <u>REMOVAL</u>	23b. DATE <u>5-10-59</u>	23c. NAME OF CEMETERY OR CREMATORY <u>VALHALLA Fun Home -</u>	23d. LOCATION (City, town, or county) (State) <u>PUEBLO</u> <u>COLO.</u>
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24. FUNERAL DIRECTOR <u>CRUNK-WALKER - Lexington, Mo.</u>	25. DATE RECD. BY LOCAL REG. <u>5-20-59</u>	26. REGISTRAR'S SIGNATURE <u>Marion Gustafson</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.

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 *Harold J. Walker*

Licensed Embalmer No. *4588*

P. O. Address *Leakington, N.C.*

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.