

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

59-018631

STATE FILE NUMBER

FILED MAY 18 1959 Registration District No. 274 Primary Registration District No. 3052 Registrar's No. 164

S. 300
1-57

Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed. All diseases in Part I must be causally related.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE
MEDICAL CERTIFICATION

1. PLACE OF DEATH a. COUNTY <u>Pettis</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Pettis</u>				
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Sedalia</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		c. CITY OR TOWN <u>Sedalia</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>Campbell Nursing Home</u>			Length of stay in lb <u>12 1/2 yrs</u>		d. STREET ADDRESS (If outside, give location) <u>900 East 6th</u>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>AMANDA</u> Middle <u>E.</u> Last <u>FRY</u>				4. DATE OF DEATH Month <u>May</u> Day <u>11</u> Year <u>1959</u>				
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>May 4 1875</u>		
9. AGE (In years last birthday) <u>84</u>		IF UNDER 1 YEAR Months <u> </u> Days <u> </u>		IF UNDER 24 HRS. Hours <u> </u> Min. <u> </u>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Garment Worker</u>		
10b. KIND OF BUSINESS OR INDUSTRY <u>factory</u>		11. BIRTH PLACE (City and state or country) <u>Indiana</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A</u>				
13a. FATHER'S NAME <u>David B. Peugh</u>			13b. MOTHER'S MAIDEN NAME <u>unknown</u>			14. NAME OF HUSBAND OR WIFE <u>George Wilbur Fry</u>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or date of service) <u>no</u>		16. SOCIAL SECURITY NO. <u>no</u>		17. INFORMANT <u>George Fry</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>Cerebral haemorrhage</u> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. } DUE TO (b) <u>hypertension, essential</u> DUE TO (c) <u> </u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u> </u>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> <u>331x</u>	
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.) <u> </u>					
20c. TIME OF INJURY Hour <u> </u> Month <u> </u> Day <u> </u> Year <u> </u> a.m. <u> </u> p.m. <u> </u>			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.) <u> </u>			20f. CITY, TOWN, OR LOCATION <u>Sedalia Mo</u>		COUNTY <u> </u> STATE <u> </u>			
21. I attended the deceased from <u>3-14-59</u> to <u>5-11-59</u> and last saw her alive on <u>5-11-59</u> Death occurred at <u>6:35 P.</u> m on the date stated above, and to the best of my knowledge, from the causes stated.								
22a. SIGNATURE <u>Chas Jordan Steuffer MD</u> (Degree or title)				22b. ADDRESS <u>Sedalia Mo</u>		22c. DATE SIGNED <u>5-12-59</u>		
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE <u>5-13-59</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Crown Hill</u>		23d. LOCATION (City, town, or county) (State) <u>Sedalia Mo</u>		
24. FUNERAL DIRECTOR <u>McLaughlin Bros</u> ADDRESS <u>Sedalia</u>			25. DATE RECD. BY LOCAL REG. <u>5/12/1959</u>		26. REGISTRAR'S SIGNATURE <u>Frances Shelby</u>			

MAY 19 1959

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 K.P. McGray
Licensed Embalmer No. 315-3
P. O. Address Sedalia, Mo

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.