Health, & Welfare Public Service

S. 300
1-57

THE DIVISION OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

59-020256
STATE FILE NUMBER

FILED JUN 29 1959 Registration District No. 1 Primary Registration District No. 3000 Registrar's No. 192

1. PLACE OF DEATH
a. COUNTY: Adair
b. CITY OR TOWN: Kirksville — Inside Limits: Yes [X] No [ ]
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR: ~~XXXXXXX~~Grim-Smith — Length of stay in 1b: 4½ mos.

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Missouri b. COUNTY: Adair
c. CITY OR TOWN: Kirksville — Inside Limits: Yes [X] No [ ]
d. STREET ADDRESS (If outside, give location): 415 N. Mulanix — Reside on Farm: Yes [X] No [ ]

3. NAME OF DECEASED (Type or print): First: Ella Middle: Angevine Last:
4. DATE OF DEATH: Month 6 Day 19 Year 59

5. SEX: female
6. COLOR OR RACE: white
7. MARITAL STATUS: MARRIED [ ] NEVER MARRIED [ ] WIDOWED [X] DIVORCED [ ]
8. DATE OF BIRTH: Jan. 18, 1866
9. AGE (In years on last birthday): 93 — IF UNDER 1 YEAR: Months 5 Days 1 — IF UNDER 24 HRS: Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Matron of Hospital
10b. KIND OF BUSINESS OR INDUSTRY: Medical
11. BIRTHPLACE (City and state or country): Muskingdon Co. Ohio
12. CITIZEN OF WHAT COUNTRY? USA

13a. FATHER'S NAME: John Anderson
13b. MOTHER'S MAIDEN NAME: Rachel Schrake
14. NAME OF HUSBAND OR WIFE:

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.:
17. INFORMANT: Roy Anderson Address: Kirksville, Mo.

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) Cerebral hemorrhage — INTERVAL BETWEEN ONSET AND DEATH: 2 mos.
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.
DUE TO (b) Arteriosclerosis — 2 yrs.
DUE TO (c)
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a): 331x

19. WAS AUTOPSY PERFORMED? YES [ ] NO [X]

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 April 27, 1959, to June 19, 1959 and last saw ~~him~~ her alive on June 19, 1959
Death occurred at 5:20 p.m. on the date stated above; and to the best of my knowledge, from the causes stated.

22a. SIGNATURE: J. B. Jones M.D. (Degree or title)
22b. ADDRESS: 201 E. Patterson, Kirksville, Mo.
22c. DATE SIGNED: 6-22-59

23a. BURIAL, CREMATION, REMOVAL (Specify): burial
23b. DATE: 6/22/59
23c. NAME OF CEMETERY OR CREMATORY: Maple Hills Cemetery
23d. LOCATION (City, town, or county) (State): Kirksville, Mo.

24. FUNERAL DIRECTOR: Davis & Davis ADDRESS: Kirksville
25. DATE RECD. BY LOCAL REG.: 6-23-1959
26. REGISTRAR'S SIGNATURE: Dorris W. Ratcliff

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

J. B. Jones, M.D.

MAR 17 1964

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 Robert B. Hamer

Licensed Embalmer No. 4219

P. O. Address Kirksville

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.