

THE DIVISION OF HEALTH OF MISSOURI
 STANDARD CERTIFICATE OF DEATH

59-020314

STATE FILE NUMBER

JUL 13 1959

Registration District No. 10

Primary Registration District No. 3002

Registrar's No. 133

V. S. 300
 Rev. 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

1. PLACE OF DEATH a. COUNTY Audrain		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Mo b. COUNTY Montgomery	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Mexico Mo		c. CITY OR TOWN New Florence Mo	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Audrain County Hospital		Length of stay in lb	
3. NAME OF DECEASED (Type or print) First William Middle H Last VanStuddiford		4. DATE OF DEATH Month June Day 30 Year 1959	
5. SEX B	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH March-26-1884
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and state or country) Jonesburg Mo
13a. FATHER'S NAME Thomas Van Studdiford		13b. MOTHER'S MAIDEN NAME Elizabeth Ball	14. NAME OF HUSBAND OR WIFE Nellie VanStuddiford
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. None	17. INFORMANT Address Mrs Nellie VanStuddiford New Florence Mo
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Congestive Heart Failure Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. } DUE TO (b) Coronary Heart Disease DUE TO (c) Hypostatic Pneumonia 2 days			INTERVAL BETWEEN ONSET AND DEATH 1 week 5 yrs
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 <input type="checkbox"/> NOT WHILE <input type="checkbox"/> WORK 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 6-25-59 to 6-30-59 and last saw ^{her} him alive on 6-30-59 Death occurred at 9:45 AM on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree or title) Ernest J. Smith M.D.		22b. ADDRESS Mexico, Mo	
22c. DATE SIGNED 6-30-59			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE July-2-1959	
23c. NAME OF CEMETERY OR CREMATORY Calvary Cemetery Mo		23d. LOCATION (City, town, or county) (State) St. Louis, Mo	
24. FUNERAL DIRECTOR ADDRESS Baker Funeral Home New Florence Mo		25. DATE RECD. BY LOCAL REG. June 30-1959	
		26. REGISTRAR'S SIGNATURE Blanche Neely	

REC'D BY UNIT

VS AUG 10 1950

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 *R. B. Baker*

Licensed Embalmer No....3375.....

P. O. Address..New..Forence,..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.