

DEPARTMENT OF HEALTH - STANDARD CERTIFICATE OF DEATH

59-021916

FILED JUL 8 1959 / 157

Registration District No. _____ Primary Registration District No. 3028 Registrar's No. 125

STATE FILE NUMBER

1. PLACE OF DEATH a. COUNTY Jasper b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Carthage Length of stay in 1b 80 yrs. c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION McCune Brooks Hosp. Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY Jasper c. CITY OR TOWN Carthage Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> d. STREET ADDRESS (If outside, give location) 701 Cedar St. Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) First Orpha Middle Nancy Last Fry			4. DATE OF DEATH Month July Day 1 Year 1959					
5. SEX Female	6. COLOR OR RACE White	7. Married <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH 3-29-66	9. AGE (last birthday) 93	IF UNDER 1 YEAR Months _____ Days _____ Hours _____ Min. _____ IF UNDER 24 HR Hours _____ Min. _____			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		10b. KIND OF BUSINESS OR INDUSTRY None		11. BIRTHPLACE (City and state or country) Plymouth, Ill		12. CITIZEN OF WHAT COUNTRY U.S.A.		
13a. FATHER'S NAME Solomon Fry			13b. MOTHER'S MAIDEN NAME Nancy E. Polite			14. NAME OF HUSBAND OR WIFE Never Married		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. None		17. INFORMANT Address Carl Fry - Carthage, Missouri				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Severe circulatory failure DUE TO (b) Arteriosclerotic heart disease DUE TO (c) _____ Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.						INTERVAL BETWEEN ONSET AND DEATH 8 days 20 years		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) Hypertension, severe Generalized arteriosclerosis						PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown		
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	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 _____ a.m. _____ p.m. Month, Day, Year _____		20d. INJURY OCCURRED WHILE AT WORK <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.)			20f. CITY, TOWN, OR LOCATION		COUNTY		STATE	
21. I attended the deceased from <u>11/19/16</u> to <u>7/1/59</u> and last saw her/him alive on <u>6/30/59</u> Death occurred at <u>7:10A.</u> m on the date stated above, and to the best of my knowledge, from the causes stated.								
22a. SIGNATURE (Degree or title) <i>Charles A. Scheel M.D.</i>				22b. ADDRESS Carthage, Mo.			22c. DATE SIGNED 7-1-59	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 7-3-59		23c. NAME OF CEMETERY OR CREMATORY Park Cemetery		23d. LOCATION (City, town, or county) (State) Carthage, Missouri		
24. FUNERAL DIRECTOR ADDRESS Ulmer Funeral Home - Carthage, Mo.				25. DATE RECD. BY LOCAL REG. 7-2-59		26. REGISTRAR'S SIGNATURE <i>Ely Clinton</i>		

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

APR 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

or by _____, Student Embalmer No. _____

working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed *Edwin S. [Signature]*

Licensed Embalmer No. 495

P. O. Address *Carthage*

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to do so 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.