Health, Welfare Public Service

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THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

59-021988
STATE FILE NUMBER

FILED JUN 29 1959 Registration District No. 164 Primary Registration District No. 3032 Registrar's No. 84

1. PLACE OF DEATH
a. COUNTY Johnson
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Warrensburg — Inside Limits Yes X No ☐
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Warrensburg Hosp — Length of stay in 1b 8 days

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Missouri b. COUNTY Lafayette
c. CITY OR TOWN Odessa, RFD 2 — Inside Limits Yes ☐ No X
d. STREET ADDRESS (If outside, give location) 5 mi. East — Reside on Farm Yes X No ☐

3. NAME OF DECEASED (Type or print) First Ruby Middle Maxine Last Bybee
4. DATE OF DEATH Month June Day 20 Year 1959
5. SEX female
6. COLOR OR RACE white
7. MARRIED X NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH Sept 15,1923
9. AGE (In years last birthday) 35
IF UNDER 1 YEAR Months Days — IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife
10b. KIND OF BUSINESS OR INDUSTRY farming
11. BIRTHPLACE (City and state or country) Odessa, Missouri
12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME T. R. McGirl
14. MOTHER'S MAIDEN NAME Ruth Wilson
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. 495-20-6513
17. INFORMANT Address James O. Bybee, Odessa, Mo. R.2

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] — INTERVAL BETWEEN ONSET AND DEATH
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Ventricular Fibrillation
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.
DUE TO (b) Heart Block Complete A-V disassociation
DUE TO (c) Rheumatic Heart disease
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)
Hyperactive Thyroid 416X
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 6-11-59, to 6-20-59 and last saw her alive on 6-20-59
Death occurred at 3 30 A m on the date stated above; and to the best of my knowledge, from the causes stated.
22a. SIGNATURE Keith D. Jones (Degree or title) MD
22b. ADDRESS Warensburg Mo
22c. DATE SIGNED 6-22-59

Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed. All diseases in Part I must be casually related. Coroner cannot certify to a death due to natural causes.
USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

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23a. BURIAL, CREMATION, REMOVAL (Specify) burial
23b. DATE 6-22-59
23c. NAME OF CEMETERY OR CREMATORY Odessa Cemetery
23d. LOCATION (City, town, or county) (State) Odessa, Lafayette, Mo.
24. FUNERAL DIRECTOR Ralph O. Jones ADDRESS Odessa, Mo.
25. DATE REC'D BY LOCAL REG. June 22 1959
26. REGISTRAR'S SIGNATURE Savannah Pritchfield

(Licensed Embalmer's Statement on Reverse Side)

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was eml

by me, or by ....., Student Embalmer No.....

working under my personal supervision..

Student.....
Signature of Student Embalmer

Signed Ralph O. Jones

Licensed Embalmer No. 46

P. O. Address Odessa

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (F
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.