

Health, Welfare, Public Service

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ALL DISASES IN PART I MUST BE SPECIALLY REPORTED TO THE HEALTH DEPARTMENT BY THE REGISTRAR. USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE.
EARL NAUGHLIN JR. D.D.

STANDARD CERTIFICATE OF DEATH

STATE FILE NUMBER

FILED VS AUG 4 1959

Registration District No. 1 Primary Registration District No. 3000 Registrar's No. 228

1. PLACE OF DEATH a. COUNTY Adair		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY Lewis	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN KIRKSVILLE		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN Ewing
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION LAUGHLIN		Length of stay in 1b	d. STREET ADDRESS (If outside, give location) 0560
3. NAME OF DECEASED (Type or print) First Middle Last JAMES WM. GLISAN			4. DATE OF DEATH Month Day Year July 26 1959
5. SEX Male	6. COLOR OR RACE wh	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Jan 27. 1881 78
9a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer		9b. KIND OF BUSINESS OR INDUSTRY General	9c. BIRTHPLACE (City and state or country) Missouri
10a. FATHER'S NAME James Wm Glisan		10b. MOTHER'S MAIDEN NAME not known	10c. NAME OF HUSBAND OR WIFE
11. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no		12. SOCIAL SECURITY NO. 4201	13. INFORMANT Evelyn G. Bryant Address LaBelle Mo
14. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) DELAYED POST. SURGICAL SHOCK			INTERVAL BETWEEN ONSET AND DEATH 1 HOUR
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) CORONARY ARTERY DISEASE AND HEART BLOCK			UNKNOWN
DUE TO (c) OLD MYOCARDIAL INFARCT			"
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) TREMENDOUS PROSTATIC HYPERTROPHY			15. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
16a. ACCIDENT SUICIDE HOMICIDE <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>		16b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)	
16c. TIME OF INJURY Hour Month, Day, Year a.m. p.m.			
16d. INJURY OCCURRED WHILE AT <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	16e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	16f. CITY, TOWN, OR LOCATION	COUNTY STATE
17. I attended the deceased from 7-16-59 to 7-26-59 and last saw ^{her} _{him} alive on 7-25-59 Death occurred at 4:25 A m on the date stated above; and to the best of my knowledge, from the causes stated.			
18a. SIGNATURE (Degree or title) Earl Naughlin Jr. D.D.		18b. ADDRESS Kirksville Mo	18c. DATE SIGNED 7-26-59
19a. BURIAL, CREMATION, REMOVAL (Specify)	19b. DATE July 29-	19c. NAME OF CEMETERY OR CREMATORY Maconic	19d. LOCATION (City, town, or county) (State) Ewing Mo
20. FUNERAL DIRECTOR ADDRESS Thomas Ball Ewing Mo		21. DATE RECD. BY LOCAL REG. 7-26-1959	22. REGISTRAR'S SIGNATURE Doris W. Ratliff

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. M. Crabbell*

Licensed Embalmer No. *490*
P. O. Address *E. Irving*

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.