

RI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

59-024360

FILED VS AUG 4 1959

Registration District No. 47 Primary Registration District No. 3008 Registrar's No. 199

STATE FILE NUMBER

1. PLACE OF DEATH a. COUNTY <u>Callaway</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Knox</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Fulton</u>		Length of stay in 1b <u>20 days</u>	c. CITY OR TOWN <u>Baring, Missouri</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>State Hospital No. 1</u>		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>

3. NAME OF DECEASED (Type or print) First <u>JOSEPH</u> Middle <u>COURTNEY</u> Last <u>COURTNEY</u>			4. DATE OF DEATH Month <u>July</u> Day <u>29</u> Year <u>1959</u>		
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. Married <input checked="" type="checkbox"/> Never Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <u>11 Dec 1909</u>	9. AGE (last birthday) <u>49</u>	IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min. <u>  </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farm laborer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Farming</u>		11. BIRTHPLACE (City and state or country) <u>Missouri</u>	12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>
13a. FATHER'S NAME <u>Joseph Courtney</u>		13b. MOTHER'S MAIDEN NAME <u>Clara Daling</u>		14. NAME OF HUSBAND OR WIFE <u>None</u>	

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>World War #2</u>	16. SOCIAL SECURITY NO. <u>498-05-7575</u>	17. INFORMANT <u>Mother,</u>	Address <u>Baring, Mo.</u>
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18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pulmonary edema and congestion</u>		INTERVAL BETWEEN ONSET AND DEATH
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) <u>Coronary insufficiency</u>	
	DUE TO (c) <u>Arteriosclerotic heart disease</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)		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 <u>  </u> a.m. <u>  </u> p.m. <u>  </u>	Month <u>  </u> Day <u>  </u> Year <u>  </u>		
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 <u>  </u>	COUNTY <u>  </u> STATE <u>  </u>

21. I attended the deceased from July 9, 1959 to July 29, 1959 and last saw him alive on July 29, 1959  
Death occurred at 10 a.    m on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE <u>Erin Ben [Signature]</u>	(Degree or title) <u>  </u>	22b. ADDRESS <u>State Hospital No. 1, Fulton, Mo.</u>	22c. DATE SIGNED <u>7-29-59</u>
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE <u>July 31, 1959</u>	23c. NAME OF CEMETERY OR CREMATORY <u>St. Joseph Catholic Cem</u>	23d. LOCATION (City, town, or county) (State) <u>Edina M</u>

24. FUNERAL DIRECTOR <u>Hallace Funeral Home, Fulton, Mo</u>	ADDRESS <u>  </u>	25. DATE RECD. BY LOCAL REG. <u>July 29 - 1959</u>	26. REGISTRAR'S SIGNATURE <u>Maritta Lawrence</u>
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DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

AUG 6 1959

AUG 5 1959

**STATEMENT BY LICENSED EMBALMER**

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by \_\_\_\_\_, Student Embalmer No. \_\_\_\_\_ or by \_\_\_\_\_, Student Embalmer No. \_\_\_\_\_ working under my personal supervision.

Student \_\_\_\_\_  
Signature of Student Embalmer

Signed \_\_\_\_\_

Licensed Embalmer No. 4994

P. O. Address Fulton N.

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.