

R DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

FILED VS AUG 13 1959

59-024490

STATE FILE NUMBER

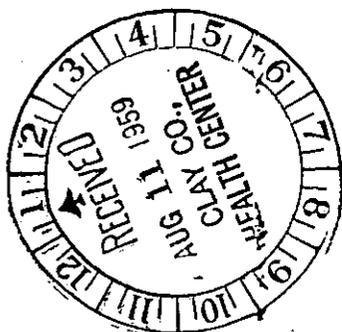
Registration District No. 71 Primary Registration District No. 3012 Registrar's No. 75

| | | | | | | |
|--|---|---|---|---|---|-------|
| 1. PLACE OF DEATH a. COUNTY <u>Clay</u> | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Clay</u> | | | |
| b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Excelsior Springs</u> | | Length of stay in 1b <u>9 years</u> | c. CITY OR TOWN <u>Excelsior Springs</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>334 E Excelsior</u> | | Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> | d. STREET ADDRESS (If outside, give location) <u>334 E Excelsior</u> | | Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) First <u>Mattie</u> Middle <u>Jane</u> Last <u>Webb</u> | | | 4. DATE OF DEATH Month <u>July</u> Day <u>31</u> Year <u>1959</u> | | | |
| 5. SEX <u>female</u> | 6. COLOR OR RACE <u>White</u> | 7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/> | 8. DATE OF BIRTH <u>Nov 9, 1871</u> | 9. AGE (last birthday) <u>87</u> | IF UNDER 1 YEAR Months _____ Days _____ Hours _____ Min. _____ | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u> | | 10b. KIND OF BUSINESS OR INDUSTRY <u>Home</u> | 11. BIRTHPLACE (City and state or country) <u>Tennessee</u> | | 12. CITIZEN OF WHAT COUNTRY <u>U.S. A.</u> | |
| 13a. FATHER'S NAME <u>John Marion</u> | | 13b. MOTHER'S MAIDEN NAME <u>Unknown</u> | | 14. NAME OF HUSBAND OR WIFE | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u> | 16. SOCIAL SECURITY NO. <u>None</u> | | 17. INFORMANT Address <u>Mrs Alice Etheridge, Excelsior Springs, Mo</u> | | | |
| 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>Cerebral hemorrhage</u> <u>hypertension</u> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) _____ DUE TO (c) <u>arteriosclerosis</u> | | | | | INTERVAL BETWEEN ONSET AND DEATH | |
| 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 checked="" 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>July 10, 1959</u> to <u>July 31, 1959</u> and last saw <u>her</u> alive on <u>July 31, 1959</u> Death occurred at <u>6:00 pm</u> m on the date stated above, and to the best of my knowledge, from the causes stated. | | | | | | |
| 22a. SIGNATURE <u>M. D. Excelsior</u> (Degree or title) | | | 22b. ADDRESS <u>M. D. Excelsior Springs, Mo.</u> | | 22c. DATE SIGNED <u>7/31/59</u> | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u> | 23b. DATE <u>8-1-59</u> | 23c. NAME OF CEMETERY OR CREMATORY <u>Unknown</u> | | 23d. LOCATION (City, town, or county) (State) <u>Dallas, Texas</u> | | |
| 24. FUNERAL DIRECTOR'S ADDRESS <u>Richard Funeral Home, Inc. Excelsior Springs, Missouri</u> | | | 25. DATE RECD. BY LOCAL REG. <u>8-1-59</u> | 26. REGISTRAR'S SIGNATURE <u>Caroline Hutchings</u> | | |

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF



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 Ralph Van Landingham

Licensed Embalmer No. 4009

P. O. Address Chelton Springs, S.C.

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.