

RI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

59-025836

FILED VS JUL 27 1959

3038

STATE FILE NUMBER

Registration District No. 784 Primary Registration District No. 5689 Registrar's No. 68

DEED

8-21-59

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DOCUMENT Certified statement fr Bible rcd.

MEDICAL CERTIFICATION

BY AFFIDAVIT OF informant

1. PLACE OF DEATH a. COUNTY Linn				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Mo b. COUNTY Chariton			
b. CITY (If outside corporate limits, give TOWNSHIP only) Brookfield		Length of stay in 1b		c. CITY OR TOWN Keytesville		Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Highway 36 & 11			Inside Limits Yes <input checked="" type="checkbox"/> No <input checked="" type="checkbox"/>	d. STREET ADDRESS (If outside, give location) R.F.D.		Reside on Farm Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Sidney Middle Alice Last Bushnell			4. DATE OF DEATH Month 7 Day 17 Year 1959				
5. SEX F	6. COLOR OR RACE W	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>		8. DATE OF BIRTH 3/1/1884	9. AGE (last birthday) 75	IF UNDER 1 YEAR Months 4 Days 16 Hours Min. 	IF UNDER 24 HR
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (City and state or country) Chariton, Co.	12. CITIZEN OF WHAT COUNTRY U.S.A.	
13a. FATHER'S NAME Guss Coleman			13b. MOTHER'S MAIDEN NAME Elizabeth Grubbs		14. NAME OF HUSBAND OR WIFE Steve		
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. 490-30-3011	17. INFORMANT Address Effie McNally Keytesville, Mo				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Multiple Cerebrovascular							INTERVAL BETWEEN ONSET AND DEATH none
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.			DUE TO (b)		DUE TO (c)		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (e)					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 checked="" 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.) Car accident 36 & 11 Junction				
20c. TIME OF INJURY approx 11:55 p.m.		Month, Day, Year 7-17-59					
20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) 36 & 11 Jct	20f. CITY, TOWN, OR LOCATION Brookfield	COUNTY Linn	STATE Mo		
21. I attended the deceased from _____ to _____ and last saw her/him alive on _____ Death occurred at approx 11:55 A m on the date stated above, and to the best of my knowledge, from the causes stated.							
22a. SIGNATURE (Degree or title) James B McCallard Coronor				22b. ADDRESS Brookfield Mo		22c. DATE SIGNED 7/19/59	
23a. BURIAL, CREMATION, REMOVAL (Specify) B	23b. DATE 7.19/1959	23c. NAME OF CEMETERY OR CREMATORY Mt. Pleasant		23d. LOCATION (City, town, or county) Keytesville, Mo		(State)	
24. FUNERAL DIRECTOR James McLaughlin			ADDRESS Marceline Ia, Mo	25. DATE RECD. BY LOCAL REG. 7-18-59	26. REGISTRAR'S SIGNATURE Katharine Johnson		

JUL 28 1960

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JUL 14 1960

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JUL 28 1960

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 James B. McCallard

Licensed Embalmer No. 4230

P. O. Address Brookfield

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