

RI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

59-025865

FILED VS JUL 29 1959

Registration District No. 107 Primary Registration District No. 3040 Registrar's No. 198

STATE FILE NUMBER

1. PLACE OF DEATH a. COUNTY <u>Livingston</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Carroll</u>				
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Chillicothe</u>		Length of stay in 1b <u>15 Mo</u>		c. CITY OR TOWN <u>HALE</u>		Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>		
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>421 Clay St.</u>			Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>		d. STREET ADDRESS (If outside, give location) <u>RR#</u>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>WEEPY</u> Middle <u>D.</u> Last <u>FOLTZ</u>				4. DATE OF DEATH Month <u>July</u> Day <u>25</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>6-23-1867</u>	9. AGE (last birthday) <u>92</u>	10. UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	11. IF UNDER 24 HR 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>HOUSEWIFE</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>HOME</u>		11. BIRTHPLACE (City and state or country) <u>CARROLL CO.</u>		12. CITIZEN OF WHAT COUNTRY <u>U.S.A</u>	
13a. FATHER'S NAME <u>SAMUEL HUFFMAN</u>			13b. MOTHER'S MAIDEN NAME <u>MARTHA VAUGHN</u>			14. NAME OF HUSBAND OR WIFE <u>WELANDER M. FOLTZ</u>		
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>ANONE</u>		17. INFORMANT Address <u>ORLA FOLTZ HALE, 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>Myocarditis</u> DUE TO (b) <u>arteriosclerosis</u> DUE TO (c) <u> </u> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.							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 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> Month, Day, Year. a.m. <u> </u> p.m. <u> </u>			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.)		20f. CITY, TOWN, OR LOCATION COUNTY STATE	
21. I attended the deceased from <u>7-4-59</u> to <u>7-25-59</u> and last saw her <u>alive</u> on <u>7-25-59</u> . Death occurred at <u>3:15 P.</u> on the date stated above, and to the best of my knowledge, from the causes stated.								
22a. SIGNATURE <u>Joseph F. Gale</u> (Degree or title)				22b. ADDRESS <u>Chillicothe Mo</u>			22c. DATE SIGNED <u>7-27-59</u>	
23a. BURIAL, CREMATION, OR REMOVAL (Specify)		23b. DATE	23c. NAME OF CEMETERY OR CREMATORY			23d. LOCATION (City, town, or county) (State)		
<u>BURIAL</u>		<u>July 27-59</u>	<u>ELIZABETH</u>			<u>HALE MISSOURI</u>		
24. FUNERAL DIRECTOR ADDRESS <u>Austin FUNERAL HOME, HALE, MO.</u>				25. DATE RECD. BY LOCAL REG. <u>7/27/59</u>		26. REGISTRAR'S SIGNATURE <u>Frances B. Neill</u>		

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

MAR 29 1961

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 B. J. Lindley

Licensed Embalmer No. 4922

P. O. Address Chillicothe

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.