

RI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

59-025866

FILED VS JUL 29 1959

Registration District No. 187 Primary Registration District No. 308 Registrar's No. 190

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>Macon</u>					
b. CITY (If outside corporate limits, give TOWNSHIP only) <u>Chillicothe</u>		Length of stay in lb <u>2 Days</u>		c. CITY OR TOWN <u>Macon</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>Chillicothe Hosp.</u>			Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location) <u>1011 N. Rutheford</u>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First <u>Cora</u> Middle <u>Belle</u> Last <u>Gaunt</u>				4. DATE OF DEATH Month <u>July</u> Day <u>18</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>3/20/1869</u>	9. AGE (last birthday) <u>90</u>		IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	IF UNDER 24 HR 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> </u>		11. BIRTHPLACE (City and state or country) <u>Randolph, Cty. Mo.</u>		12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>		
13a. FATHER'S NAME <u>William Butler</u>			13b. MOTHER'S MAIDEN NAME <u>Lucinda Patton</u>			14. NAME OF HUSBAND OR WIFE <u>Dec.</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>No.</u>		17. INFORMANT <u>Mrs. J.D. Cooper</u> Address <u>Macon, 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>Dehydration & Electrolyte imbalance</u>							INTERVAL BETWEEN ONSET AND DEATH <u>1 week</u>		
DUE TO (b) <u>Intestinal obstruction</u>							<u>12 days</u>		
DUE TO (c) <u>Adhesions</u>							<u>Unknown</u>		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (e) <u>Senility & Arteriosclerosis</u>							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, Day, Year <u> </u> / <u> </u> / <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		COUNTY		STATE	
21. I attended the deceased from <u>July 6, 1959</u> to <u>July 18, 1959</u> and last saw her alive on <u>July 17, 1959</u> Death occurred at <u>6:35 A.m.</u> on the date stated above, and to the best of my knowledge, from the causes stated.									
22a. SIGNATURE (Deceased's title) <u>William L. Fair, M.D.</u>				22b. ADDRESS <u>Chillicothe, Mo</u>				22c. DATE SIGNED <u>7/29/59</u> (State)	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE <u>7/20/1959</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Oakwood Cem.</u>		23d. LOCATION (City, town, or county) <u>Macon, Mo.</u>				
24. FUNERAL DIRECTOR <u>Lester Whitton</u> ADDRESS <u>Macon, Mo.</u>			25. DATE RECD. BY LOCAL REG. <u>7/22/59</u>		26. REGISTRAR'S SIGNATURE <u>Thomas O'Neil</u>				

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

JUL 29 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 _____ or by _____, Student Embalmer No. _____ working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed Billy H. Bender

Licensed Embalmer No. 5034

P. O. Address Macon

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.