

RI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

59-025867

FILED VS AUG 11 1959/87

Registration District No. \_\_\_\_\_ Primary Registration District No. 3040 Registrar's No. 206

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>Mo.</u> b. COUNTY <u>Carroll</u>			
b. CITY (If outside corporate limits, give TOWNSHIP only) <u>Chillicothe</u>		Length of stay in 1b <u>15 Months</u>		c. CITY OR TOWN <u>RED CARROLLTON</u>		Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) <u>BUSINS Nursing Home</u>				d. STREET ADDRESS _____		Reside on Farm Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Odessa Florence Green</u>				4. DATE OF DEATH Month <u>August</u> Day <u>5</u> Year <u>1959</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>		8. DATE OF BIRTH <u>6-18-1884</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>House Wife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>House Wife</u>		11. BIRTHPLACE (City and state or country) <u>Carroll County, Mo.</u>		12. CITIZEN OF WHAT COUNTRY <u>USA</u>	
13a. FATHER'S NAME <u>H. W. Anderson</u>			13b. MOTHER'S MAIDEN NAME <u>Mary Howard</u>			14. NAME OF HUSBAND OR WIFE <u>John E. Green</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. _____		17. INFORMANT <u>John E. Green, Carrollton, 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>Chr myocarditis</u> <u>arteriosclerosis.</u> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____							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) <u>Carcinoma of Bladder</u>						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 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>7-13-59</u> to <u>8-4-59</u> and last saw her <sup>him</sup> alive on <u>8-4-59</u> Death occurred at <u>7:45 A.m.</u> on the date stated above, and to the best of my knowledge, from the causes stated.							
22a. SIGNATURE <u>Dr. M. D. Drwell, M.D.</u>				22b. ADDRESS <u>Chillicothe Mo</u>		22c. DATE SIGNED <u>8/5/59</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE <u>8-7-59</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Ebenezer</u>		23d. LOCATION (City, town, or county) <u>Boyard, Missouri</u>	
24. FUNERAL DIRECTOR <u>Distarron Farm Home</u>				25. DATE RECD. BY LOCAL REG. <u>8/5/59</u>		26. REGISTRAR'S SIGNATURE <u>Frances B Neill</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 Samuel M. Rice, Student Embalmer No. 577

working under my personal supervision.

Student Samuel M. Rice  
Signature of Student Embalmer

Signed R. M. Anderson

Licensed Embalmer No. 4469  
P. O. Address Chickston

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.