

RI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

59-025890

FILED VS JUL 29 1959

Registration District No. 187 Primary Registration District No. 1 Registrar's No. 184 STATE FILE NUMBER

DED

1. PLACE OF DEATH a. COUNTY <u>Livingston</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before address) a. STATE <u>Missouri</u> b. COUNTY <u>Livingston</u>			
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Chula</u>		Length of stay in 1b <u>19 Years</u>		c. CITY OR TOWN <u>Chula</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>Cream Ridge Twp. W.M.E.</u>			Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <u>Cream Ridge W.M.E. Chula.</u>			Reside on Farm Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <u>Thirza</u> Middle <u>Jane</u> Last <u>St John</u>				4. DATE OF DEATH Month <u>July</u> Day <u>16</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>Oct 10 1871</u>	9. AGE (last birthday) <u>87</u>	IF UNDER 1 YEAR Months <u>9</u> Days <u>6</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>Home</u>	11. BIRTHPLACE (City and state or country) <u>Livingston Co Mo</u>		12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>	
13a. FATHER'S NAME <u>Dandridge Ward</u>			13b. MOTHER'S MAIDEN NAME <u>Mary E. Minor</u>		14. NAME OF HUSBAND OR WIFE <u>Joseph St John</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>None</u>	17. INFORMANT Address <u>Alpha Meservey Chula 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>Coronary occlusion</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 <u>38 hrs</u> <u>?</u>
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> a.m. <u></u> p.m. <u></u>	Month, Day, Year <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 15 - 59</u> to <u>July 16 - 59</u> and last saw her/him alive on <u>July 16 - 59</u> Death occurred at <u>350 rd</u> on the date stated above, and to the best of my knowledge, from the causes stated.							
22a. SIGNATURE (Do not write title) <u>Joseph F. Dale M.D.</u>				22b. ADDRESS <u>Chillicothe Mo</u>		22c. DATE SIGNED <u>7-18-59</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE <u>July 19 1959</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Edgewood Cemetery</u>		23d. LOCATION (City, town, or county) <u>Chillicothe Missouri.</u>			
24. FUNERAL DIRECTOR ADDRESS <u>F.J. Roberts Funeral Home - Chula Mo</u>			25. DATE RECD. BY LOCAL REG. <u>7/18/59</u>	26. REGISTRAR'S SIGNATURE <u>Francis 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 _____, Student Embalmer No. _____

working under my personal supervision.

Student _____

Signature of Student Embalmer

Signed _____

J. M. Robertson

Licensed Embalmer No. 4388

P. O. Address Laredo, Tex.

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.