

**R DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH**

**FILED VS AUG 7 1959**

**59-025953**

STATE FILE NUMBER

Registration District No. 209 Primary Registration District No. 3043 Registrar's No. 229

1. PLACE OF DEATH a. COUNTY <b>Marion</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Missouri</b> COUNTY <b>Shelby</b>	
b. CITY (if outside corporate limits, give TOWNSHIP only) OR TOWN <b>Hannibal</b>		Length of stay in 1b <b>6 Days</b>	c. CITY OR TOWN <b>Shelbina</b> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (if NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>Levering Hospital</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <b>(If outside, give location)</b> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print) <b>Cordelia Frances Rash</b>	First <b>Cordelia</b>	Middle <b>Frances</b>	Last <b>Rash</b>	4. DATE OF DEATH <b>July 26, 1959</b>	Month <b>July</b>	Day <b>26</b>	Year <b>1959</b>
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5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <b>7/29/1875</b>	9. AGE (last birthday) <b>83</b>	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HR Hours Min.
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>	10b. KIND OF BUSINESS OR INDUSTRY <b>Own Home</b>	11. BIRTHPLACE (City and state or country) <b>Shelby County, Mo.</b>	12. CITIZEN OF WHAT COUNTRY <b>U.S.A.</b>
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13a. FATHER'S NAME <b>Thornton M. Churchwell</b>	13b. MOTHER'S MAIDEN NAME <b>Sarah C. See</b>	14. NAME OF HUSBAND OR WIFE <b>Clarence Warren Rash</b>
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>	16. SOCIAL SECURITY NO.	17. INFORMANT Address <b>Mr. C. W. Rash, Shelbina, Mo.</b>
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18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Arteriosclerotic heart disease</b>		INTERVAL BETWEEN ONSET AND DEATH
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 (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
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19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input 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.)
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20c. TIME OF INJURY Hour a.m. p.m.	Month, Day, Year
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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
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21. I attended the deceased from 21 July 1959 to 26 July 1959 and last saw her/him alive on 25 July 1959  
Death occurred at 4 AM 26 July 1959 m on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE <b>Wyneth Hamlin MD</b> (Degree or title)	22b. ADDRESS <b>Hannibal Mo</b>	22c. DATE SIGNED <b>7/29/59</b>
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23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE <b>7/28, 1959</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Mausoleum</b>	23d. LOCATION (City, town, or county) (State) <b>Shelbina, Missouri</b>
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24. FUNERAL DIRECTOR <b>Hayes Funeral Home, Shelbina, Mo.</b>	ADDRESS	25. DATE RECD. BY LOCAL REG. <b>8-3-59</b>	26. REGISTRAR'S SIGNATURE <b>Dr. E. M. Lucke By W. J. Tucker</b>
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DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

RECEIVED AUG 5 1959  
MARION CO. HEALTH DEPT.  
DATE FILED AUG 5 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 Paul E. Hoyer

Licensed Embalmer No. 446  
P. O. Address Shellina

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.