

RI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

59-026365

FILED VS AUG 5 1959

2 6965

STATE FILE NUMBER

Registration District No. _____ Primary Registration District No. _____ Registrar's No. _____

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Indiana</u> b. COUNTY <u>Clay</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>ST. LOUIS, MISSOURI</u>		c. CITY OR TOWN <u>Brazil</u>	
c. FULL NAME OF (IF NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>BARNES HOSPITAL</u>		d. STREET ADDRESS (If outside, give location) <u>Route 2</u>	

3. NAME OF DECEASED (Type or print) First <u>PHYLLIS</u> Middle <u>MARIE</u> Last <u>ATKINSON</u>			4. DATE OF DEATH Month <u>JULY</u> Day <u>24</u> Year <u>1959</u>			
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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>9/30/1931</u>	9. AGE (last birthday) <u>27</u>	IF UNDER 1 YEAR Months _____ Days _____	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) <u>Housewife</u>	10b. KIND OF BUSINESS OR INDUSTRY <u>At Home</u>	11. BIRTHPLACE (City and state or country) <u>Brazil, Ind.</u>	12. CITIZEN OF WHAT COUNTRY <u>U.S.</u>
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13a. FATHER'S NAME <u>Harry C. Brackney</u>	13b. MOTHER'S MAIDEN NAME <u>Frieda Knox</u>	14. NAME OF HUSBAND OR WIFE <u>Paul Atkinson</u>
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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) <u>No</u>	16. SOCIAL SECURITY NO. <u>Unknown</u>	17. INFORMANT Address <u>Paul Atkinson, Brazil, Ind.</u>
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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) <u>PERSISTENT ADENOCARCINOMA OF OVARIES WITH PERITONEAL METASTASES AND FECAL CUTANEOUS FISTULAS</u> DUE TO (b) _____ DUE TO (c) _____		INTERVAL BETWEEN ONSET AND DEATH <u>2 YEARS</u>
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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 checked="" type="checkbox"/> No <input type="checkbox"/> Unknown
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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.) <u>175.0</u>
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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 type="checkbox"/>	20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	20f. CITY, TOWN, OR LOCATION <u>Brazil, Ind.</u>	COUNTY _____ STATE _____
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21. I attended the deceased from JAN. 12, 1959 to JULY 24, 1959 and last saw her alive on JULY 24, 1959
Death occurred at 10:45 P.M. on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) <u>C. D. Vermillion, M.D.</u>	22b. ADDRESS <u>BARNES HOSPITAL</u>	22c. DATE SIGNED <u>7/25/59</u>
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23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>	23b. DATE <u>7-27-59</u>	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION (City, town, or county) (State) <u>Brazil, Ind.</u>
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24. FUNERAL DIRECTOR <u>Albert H. Hoppe, Inc., 4700 Washington Blvd.</u>	25. DATE RECD. BY LOCAL REG. <u>JUL 27 '59</u>	26. REGISTRAR'S SIGNATURE <u>Earl Smith, M.D.</u>
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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 Lawrence H. DeFou

Licensed Embalmer No. 493

P. O. Address So. Linn

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.