

FRI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

59-028924

FILED VS SEP 1 1959

Registration District No. 1744 Primary Registration District No. 5562 Registrar's No. 78

STATE FILE NUMBER

1. PLACE OF DEATH a. COUNTY <u>Iron</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Mo.</u> b. COUNTY <u>Iron</u>			
b. CITY (If outside corporate limits, give TOWNSHIP only) <u>Rural-Arcadia</u>		Length of stay in 1b <u>1 yr. 1 mo. 13 da.</u>		c. CITY OR TOWN <u>Rural-Arcadia</u>		Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) <u>The Home for Aged</u>			Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <u>Rural-Arcadia</u>			Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) <u>Baptists</u> <u>Orpha Jane Troutt</u>				4. DATE OF DEATH Month <u>Aug.</u> Day <u>20</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>May 20, 1873</u>	9. AGE (last birthday) <u>86</u>	IF UNDER 1 YEAR Months <u>3</u> Days	IF UNDER 24 HR Hours <u></u> Min.
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>own home</u>		11. BIRTHPLACE (City and state or country) <u>Williamson Co., Ill.</u>		12. CITIZEN OF WHAT COUNTRY <u>U.S.</u>	
13a. FATHER'S NAME <u>Powell Keaster</u>			13b. MOTHER'S MAIDEN NAME <u>Frances Bargilla Ray</u>		14. NAME OF HUSBAND OR WIFE <u>O. Troutt</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 <u>Dolores Weiss, Ironton, Mo.</u> Address			
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>Generalized arteriosclerosis.</u>						INTERVAL BETWEEN ONSET AND DEATH <u>5 years</u>	
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		
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 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>7-7-58</u> , to <u>8-20-59</u> and last saw her alive on <u>8-17-59</u> Death occurred at <u>8:35 A.</u> m on the date stated above, and to the best of my knowledge, from the causes stated.							
22a. SIGNATURE <u>Marvin C. Menney, M.D.</u> (Degree or title)				22b. ADDRESS <u>109 N. Main, Ironton, Missouri</u>			22c. DATE SIGNED <u>8-21-59</u>
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>removal</u>		23b. DATE <u>8-21-59</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Senath Missouri</u>		23d. LOCATION (City, town, or county) <u>Senath Missouri</u> (State)		
24. FUNERAL DIRECTOR <u>White Funeral Home, Ironton Mo.</u> <u>Annel White</u> ADDRESS				25. DATE RECD. BY LOCAL REG. <u>8-22-59</u>		26. REGISTRAR'S SIGNATURE <u>Mrs. Avis Jones</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 *Archie White*

Licensed Embalmer No. 3012

P. O. Address *Greenville*

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to
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.