

RI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

59-029907

FILED VS AUG 17 1959

Registration District No. 51 Primary Registration District No. Registrar's No. 192 STATE FILE NUMBER

1. PLACE OF DEATH a. COUNTY <b>Nodaway</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Missouri</b> b. COUNTY <b>Nodaway</b>					
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>Barnard - rural</b>		Length of stay in 1b <b>2 months</b>		c. CITY OR TOWN <b>Barnard</b>		Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>			
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION			Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location) <b>2 miles west</b>		Reside on Farm Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First Middle Last <b>VIRGINIA ANN DOWDEN</b>				4. DATE OF DEATH Month Day Year <b>8 11 59</b>					
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. Married <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>		8. DATE OF BIRTH <b>5/22/59</b>	9. AGE (last birthday) <b>0</b>	IF UNDER 1 YEAR Months <b>2</b> Days <b>19</b> Hours <b></b> Min. <b></b>	IF UNDER 24 HR Hours <b></b> Min. <b></b>		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>none</b>			10b. KIND OF BUSINESS OR INDUSTRY <b>none</b>		11. BIRTHPLACE (City and state or country) <b>Maryville, Mo.</b>		12. CITIZEN OF WHAT COUNTRY <b>USA</b>		
13a. FATHER'S NAME <b>Willis E. Dowden</b>			13b. MOTHER'S MAIDEN NAME <b>Cleta Wilson</b>			14. NAME OF HUSBAND OR WIFE <b>none</b>			
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. <b>none</b>		17. INFORMANT Address <b>Mrs. Willis E. Dowden, Barnard, Mo.</b>				
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>Congenital cardiac malformation (Tetralogy of Fallot)</b>							INTERVAL BETWEEN ONSET AND DEATH <b>Spinal fluid</b>		
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 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 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 <b>5/22/59</b> to <b>8/11/59</b> and last saw him/her alive on <b>8-10-59</b> Death occurred at <b>6:30 P.M.</b> on the date stated above, and to the best of my knowledge, from the causes stated.				22a. SIGNATURE (Degree or title) <b>[Signature] M. D.</b>		22b. ADDRESS <b>Maryville, Missouri</b>		22c. DATE SIGNED <b>8/12/59</b> (State)	
23a. BURIAL, CREMATION, OR REMOVAL (Specify) <b>buried</b>		23b. DATE <b>8/13/59</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Miriam</b>		23d. LOCATION (City, town, or county) <b>Maryville, Missouri</b>				
24. FUNERAL DIRECTOR ADDRESS <b>Price Funeral Home, Maryville, Mo.</b>				25. DATE RECD. BY LOCAL REG. <b>8-12-59</b>		26. REGISTRAR'S SIGNATURE <b>Bess Bolt</b>			

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 John W. Price

Licensed Embalmer No. 4281

P. O. Address Marysville

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.