

JURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

59-031228

FILED VS SEP 8 1959

STATE FILE NUMBER

Registration District No. 51 Primary Registration District No. 4515 Registrar's No. 83

1. PLACE OF DEATH a. COUNTY <u>Sullivan</u>			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Mo</u> b. COUNTY <u>Sullivan</u>			
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Milan</u>		Length of stay in 1b <u>1 week</u>	c. CITY OR TOWN <u>Milan</u>		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>Sull. Co. M. Hosp T</u>			Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First Middle Last <u>Austin Carl Rhea</u>			4. DATE OF DEATH Month Day Year <u>8-29-1959</u>			
5. SEX <u>M</u>	6. COLOR OR RACE <u>W.</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>8-1-1889</u>	9. AGE (last birthday) <u>70</u> IF UNDER 1 YEAR Months <u>0</u> Days <u>28</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>P.M. Car Inspector</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Retired</u>	11. BIRTHPLACE (City and state or country) <u>Harris - Mo</u>		12. CITIZEN OF WHAT COUNTRY <u>US</u>	
13a. FATHER'S NAME <u>John Will Rhea</u>		13b. MOTHER'S MAIDEN NAME <u>Alice E. Todd</u>		14. NAME OF HUSBAND OR WIFE <u>Sarah A McKinney</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>499-14-9655</u>	17. INFORMANT Address <u>Sarah Rhea Milan - 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>Cerebral Hemorrhage</u>					INTERVAL BETWEEN ONSET AND DEATH <u>28 hr.</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) <u>CA 50 1953, 40.</u>					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 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 <u>Milan, Mo</u>		COUNTY <u>Sullivan</u>	STATE <u>Mo</u>	
21. I attended the deceased from <u>Jan 13</u> to <u>Jan 20</u> and last saw him alive on <u>Jan 20, 1959</u> . Death occurred at <u>12 PM</u> on the date stated above, and to the best of my knowledge, from the causes stated.						
22a. SIGNATURE <u>S. J. Schone</u> (Degree or title)			22b. ADDRESS <u>Milan, Mo</u>		22c. DATE SIGNED <u>8-31-59</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE <u>8-31-59</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Oakwood Cem</u>		23d. LOCATION (City, town, or county) (State) <u>Milan - Mo</u>		
24. FUNERAL DIRECTOR <u>Schone's</u> <u>Dwight Schone</u>		ADDRESS	25. DATE RECD. BY LOCAL REG. <u>9-1-59</u>	26. REGISTRAR'S SIGNATURE <u>Mrs. M. W. Beckett</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 Dwight Schoene

Licensed Embalmer No. 2667

P. O. Address Milan - 4

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.