

IRI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

59-031302

FILED VS AUG 25 1959 360

Registration District No. 360 Primary Registration District No. 4523 Registrar's No. 184

STATE FILE NUMBER

INDEXED

1. PLACE OF DEATH a. COUNTY <u>Vernon</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Vernon</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Schell City</u>		Length of stay in 1b <u>39 yrs</u>	c. CITY OR TOWN <u>Schell City</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (IF NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>At Home.</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <u>At Home.</u> Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>

3. NAME OF DECEASED (Type or print) First <u>Joseph</u> Middle <u>Henry</u> Last <u>Teeter</u>			4. DATE OF DEATH Month <u>August</u> Day <u>16</u> Year <u>1959</u>		
5. SEX <u>male</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>Dec. 15, 1863</u>	9. AGE (last birthday) <u>95 years</u> IF UNDER 1 YEAR IF UNDER 24 HR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>farmer (retired)</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>farm</u>	11. BIRTHPLACE (City and state or country) <u>unknown</u>	12. CITIZEN OF WHAT COUNTRY <u>U. S. A</u>	

13a. FATHER'S NAME <u>Robert Frank Teeter</u>		13b. MOTHER'S MAIDEN NAME <u>Almira</u>		14. NAME OF HUSBAND OR WIFE <u>Mathie Owen Teeter</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 Address <u>Nellie Mae Dade Schell City, 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> DUE TO (b) <u>arteriosclerosis</u> DUE TO (c) _____ Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.		INTERVAL BETWEEN ONSET AND DEATH <u>1 week</u> <u>20 yrs.</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) <u>Prostatism</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	
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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.)	
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 5/20, 1959 to 8/16, 1959 and last saw ~~him~~ <sup>her</sup> alive on Aug. 15, 1959  
Death occurred at 11:30 P.M. on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) <u>M. O. Bjork, D.O.</u>		22b. ADDRESS <u>Rockville, Mo.</u>		22c. DATE SIGNED <u>8/17/59</u>
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE <u>Aug 16 1959</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Green Lawn Cemetery</u>	23d. LOCATION (City, town, or county) (State) <u>Schell City, Vernon Co. Mo.</u>	

24. FUNERAL DIRECTOR <u>Lewis &amp; Son Schell City, Mo.</u>		25. DATE RECD. BY LOCAL REG. <u>8-21-1959</u>	26. REGISTRAR'S SIGNATURE <u>Arma &amp; J. J. J. J.</u>	
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(Licensed Embalmer's Statement on Reverse Side)

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 G. Lewis*

Licensed Embalmer No. 4774

P. O. Address Schell Cir

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.