

RI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

59-031865

FILED VS OCT 7 1959 93

Registration District No. \_\_\_\_\_ Primary Registration District No. \_\_\_\_\_ Registrar's No. 59-75 STATE FILE NUMBER

DED

1. PLACE OF DEATH a. COUNTY <u>Dade</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Lorraine</u>					
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Lockwood</u>		Length of stay in lb <u>2 days</u>		c. CITY OR TOWN <u>Miller</u>		Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>			
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>Memorial Hospital</u>			Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location) <u>R.F.D.</u>		Reside on Farm Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First <u>William</u> Middle <u>M.</u> Last <u>Stone</u>				4. DATE OF DEATH Month <u>8</u> Day <u>23</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 type="checkbox"/> Divorced <input checked="" type="checkbox"/>		8. DATE OF BIRTH <u>11-23-1879</u>	9. AGE (last birthday) <u>81</u>	IF UNDER 1 YEAR Months <u>9</u> Days _____	IF UNDER 24 HR Hours _____ Min. _____		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farming</u>			10b. KIND OF BUSINESS OR INDUSTRY _____		11. BIRTHPLACE (City and state or country) <u>Missouri</u>		12. CITIZEN OF WHAT COUNTRY <u>USA</u>		
13a. FATHER'S NAME <u>Major Stone</u>			13b. MOTHER'S MAIDEN NAME <u>Eveline Hunt</u>			14. NAME OF HUSBAND OR WIFE <u>unknown</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>Gladys Staines Hindsville Ark.</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>Obstructive Biliary Cirrhosis</u> DUE TO (b) <u>Unknown</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 yr +</u>	
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>8-21-59</u> to <u>8-23-59</u> and last saw him alive on <u>8-23-59</u> Death occurred at <u>2:20</u> p.m. on the date stated above, and to the best of my knowledge, from the causes stated.									
22a. SIGNATURE (Degree or title) <u>Lee C Mc Neely M.D.</u>				22b. ADDRESS <u>Greenfield Mo.</u>			22c. DATE SIGNED <u>10-2-59</u>		
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE <u>8-26-1959</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Round Grove</u>		23d. LOCATION (City, town, or county) (State) <u>N.W. of Miller Mo.</u>				
24. FUNERAL DIRECTOR <u>Morris Leiman</u> ADDRESS <u>Miller Mo.</u>			25. DATE RECD. BY LOCAL REG. <u>10/3/1959</u>		26. REGISTRAR'S SIGNATURE <u>J. C. Canada</u>				

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

VS OCT 8 1959

**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 \_\_\_\_\_

*E. P. Seiman*

Licensed Embalmer No. 3297

P. O. Address Miller

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.