RI DIVISION OF HEALTH – STANDARD CERTIFICATE OF DEATH

59-032698

STATE FILE NUMBER

FILED VS OCT 6 1959

Registration District No. 46 Primary Registration District No. 3026 Registrar's No. 416

IDED

1. PLACE OF DEATH
a. COUNTY: Jackson
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN: Independence — Length of stay in 1b: 28 yrs
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION: Cable Rest Home — Inside Limits: Yes ☒ No ☐

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Missouri b. COUNTY: Jackson
c. CITY OR TOWN: Independence — Inside Limits: Yes ☒ No ☐
d. STREET ADDRESS (If outside, give location): 711 West South Ave — Reside on Farm: Yes ☐ No ☒

3. NAME OF DECEASED (Type or print): First: Catharine Middle: Ada Last: Scofield

4. DATE OF DEATH Month Day Year: September 16, 1959

5. SEX: Female

6. COLOR OR RACE: White

7. Married ☐ **Never Married** ☐ **Widowed** ☒ **Divorced** ☐

8. DATE OF BIRTH: 6-7-1876

9. AGE (last birthday): 83

IF UNDER 1 YEAR: Months Days — IF UNDER 24 HR: Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Home Maker

10b. KIND OF BUSINESS OR INDUSTRY: Home

11. BIRTHPLACE (City and state or country): Wisc.

12. CITIZEN OF WHAT COUNTRY: USA

13a. FATHER'S NAME: Michael Higgins

13b. MOTHER'S MAIDEN NAME: Ausgentiana Hume

14. NAME OF HUSBAND OR WIFE: Charles Scofield

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.: None

17. INFORMANT: Paul E. Anway Address: 10201 Truman Rd. Indep

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a): Encephalomalacia — INTERVAL BETWEEN ONSET AND DEATH: months

Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.
DUE TO (b): arteriosclerotic + hypertensive cardiovascular disease — years
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. ☐ Yes ☐ No ☐ Unknown

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT ☐ SUICIDE ☐ HOMICIDE ☐

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 ☐ NOT WHILE AT WORK ☐

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 1947, to 8-16-59 and last saw her/him alive on 8/12/59

Death occurred at 11:20 p.m. on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title): Vance E. Lick, MD

22b. ADDRESS: 1906 Winner Rd Independence, Mo

22c. DATE SIGNED: 9/17/59

23a. BURIAL, CREMATION, REMOVAL (Specify): Removal

23b. DATE: 9-19-1959

23c. NAME OF CEMETERY OR CREMATORY: Rose Hill Cemetery

23d. LOCATION (City, town, or county) (State): Lamoni - Iowa

24. FUNERAL DIRECTOR ADDRESS: Roland R. Speaks Indep. Mo

25. DATE RECD. BY LOCAL REG.: 9-19-59

26. REGISTRAR'S SIGNATURE: James L. Craig

(Licensed Embalmer's Statement on Reverse Side)

DOCUMENT

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_____ Signed Rollie Kessel

Signature of Student Embalmer

Licensed Embalmer No. 4690

P. O. Address Indep. M

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