

URI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

FILED VS SEP 16 1959

59-033014

STATE FILE NUMBER

Registration District No. 167 Primary Registration District No. — Registrar's No. 225

INDEXED

1. PLACE OF DEATH a. COUNTY <u>Livingston</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Mo.</u> b. COUNTY <u>Livingston</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Utica</u>		Length of stay in 1b <u>2 Months</u>	c. CITY OR TOWN <u>Chillicothe</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>Utica, Mo.</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <u>210 Cowgill</u> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print) First <u>MYRTLE</u> Middle <u>LEE</u> Last <u>BIGELOW</u>			4. DATE OF DEATH Month <u>Sept.</u> Day <u>6</u> Year <u>1959</u>		
5. SEX <u>female</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>6-28-90</u>	9. AGE (last birthday) <u>69</u>	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>home</u>	11. BIRTHPLACE (City and state or country) <u>Rover, Arkansas</u>		12. CITIZEN OF WHAT COUNTRY <u>U.S.</u>
13a. FATHER'S NAME <u>Beverly Dillard Hunt</u>		13b. MOTHER'S MAIDEN NAME <u>Mary Ann Ryan</u>		14. NAME OF HUSBAND OR WIFE <u>Ernest H. Bigelow</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>489-32-2604</u>		17. INFORMANT Address <u>Mrs. Arnold Sprague Utica, Mo.</u>	

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY:			INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a) <u>Coronary Occlusion</u>			<u>Instant</u>
DUE TO (b) <u>Coronary Sclerosis</u>			<u>3 Yrs.</u>
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 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 checked="" 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 Feb 5-56 to Sept 6-59 and last saw her her alive on Sept 1-59
Death occurred at 536 A. 24 m on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE <u>Joseph Conrad M.D</u>	(Degree or title)	22b. ADDRESS <u>Chillicothe, Mo</u>	22c. DATE SIGNED <u>Sept 8-59</u>
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE <u>9/8/1959</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Edgewood</u>	23d. LOCATION (City, town, or county) (State) <u>Chillicothe, Mo.</u>

24. FUNERAL DIRECTOR <u>NORMAN FUNERAL HOME Chillicothe</u>	ADDRESS	25. DATE RECD. BY LOCAL REG. <u>Sept-9-59</u>	26. REGISTRAR'S SIGNATURE <u>Frances B Nail</u>
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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 me
or by _____, Student Embalmer No. _____
working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed John F. Bolin

Licensed Embalmer No. 5035

P. O. Address Chillicothe,

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.