

**JURY DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH**

**59-035403**

FILED VS OCT 19 1959 47

3008

262

STATE FILE NUMBER

INDEXED

1. PLACE OF DEATH a. COUNTY <b>CALLAWAY</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MISSOURI</b> b. COUNTY <b>HOWARD</b>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>FULTON</b>		Length of stay in 1b <b>5 mos.</b>	c. CITY OR TOWN <b>ARMSTRONG</b> Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>STATE HOSPITAL NO. 1</b>		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 type="checkbox"/>

3. NAME OF DECEASED (Type or print) First <b>RICHARD</b> Middle <b>THOMAS</b> Last <b>CHILDERS</b>			4. DATE OF DEATH Month <b>October</b> Day <b>13</b> , Year <b>1959</b>	
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5. SEX <b>MALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. Married <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <b>4-15-1879</b>	9. AGE (last birthday) <b>80</b>	IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HR
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>FARM HELPER</b>	10b. KIND OF BUSINESS OR INDUSTRY <b>Farm</b>	11. BIRTHPLACE (City and state or country) <b>MISSOURI</b>	12. CITIZEN OF WHAT COUNTRY <b>U.S.A.</b>
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13a. FATHER'S NAME <b>J.G. CHILDERS</b>	13b. MOTHER'S MAIDEN NAME <b>CORDELIA PHARRIS</b>	14. NAME OF HUSBAND OR WIFE
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>UNKNOWN</b>	16. SOCIAL SECURITY NO. <b>UNKNOWN</b>	17. INFORMANT <b>STATE HOSPITAL NO. 1, FULTON, MO.</b>	Address
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18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Pulmonary Embolism</b>		INTERVAL BETWEEN ONSET AND DEATH
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)	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 checked="" 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.)
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20c. TIME OF INJURY Hour <b>10:25</b> 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
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21. I attended the deceased from <b>xx St Hosp</b> <b>May 21, 1959</b> to <b>Oct. 13, 1959</b> and last saw her/him alive on <b>XXXXXXXXXX</b>	
Death occurred at <b>10:25 a.m.</b> on the date stated above, and to the best of my knowledge, from the causes stated.	

22a. SIGNATURE (Degree or title) <i>James K. Pittman, M.D.</i>	22b. ADDRESS <b>STATE HOSPITAL NO. 1</b>	22c. DATE SIGNED <b>10-13-59</b>
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23a. BURIAL, CREMATION, REMOVAL (Specify) <b>REMOVAL</b>	23b. DATE <b>OCT. 13 1959</b>	23c. NAME OF CEMETERY OR CREMATORY <b>ASHLAND</b>	23d. LOCATION (City, town, or county) (State) <b>NEW FRANKLIN, MO.</b>
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24. FUNERAL DIRECTOR <b>MARKLAND HALL</b>	ADDRESS <b>NEW FRANKLIN, MO.</b>	25. DATE RECD. BY LOCAL REG. <b>Oct-13-1959</b>	26. REGISTRAR'S SIGNATURE <i>Maretha Lawrence</i>
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DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

NOV 1 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 Tom D. Markland

Licensed Embalmer No. 4592

P. O. Address New Frank  
Missouri

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.