

VITAL DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

FILED VS NOV 10 1959

59-035770

STATE FILE NUMBER

Registration District No. 120 Primary Registration District No. _____ Registrar's No. 98

ENDED

1. PLACE OF DEATH a. COUNTY <u>Gentry</u> b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Howard Township</u> Length of stay in 1b <u>lifetime</u> c. FULL NAME OF HOSPITAL OR INSTITUTION <u>N.E. of Lone Star</u> Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Gentry</u> c. CITY OR TOWN <u>Howard Township</u> Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> d. STREET ADDRESS (If outside, give location) <u>N.E. of Lone Star</u> Reside on Farm Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Clara</u> Middle <u>Atrell</u> Last <u>Mount</u>			4. DATE OF DEATH Month <u>October</u> Day <u>31</u> Year <u>1959</u>				
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <u>11/30/16</u>	9. AGE (last birthday) <u>42</u>	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) <u>at home</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>at home</u>		11. BIRTHPLACE (City and state or country) <u>Worth Co., Missouri</u>		12. CITIZEN OF WHAT COUNTRY <u>U.S.</u>	
13a. FATHER'S NAME <u>Elam Barber</u>			13b. MOTHER'S MAIDEN NAME <u>Emily K. Osborn</u>		14. NAME OF HUSBAND OR WIFE <u>Hunter Mount</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. _____		17. INFORMANT Address <u>Mr. Hunter Mount Albany, 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>Carcinoma (Gastro-Intestinal)</u> DUE TO (b) <u>Extreme Debilitation</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>Not Known</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 checked="" 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>Only once on Oct. 31, 1959</u> and last saw her <u>her</u> alive on <u>Oct. 31, 1959</u> Death occurred at <u>10:00 P.m.</u> on the date stated above, and to the best of my knowledge, from the causes stated.							
22a. SIGNATURE <u>D. D. Merrill</u> (Degree or title) <u>D.O.</u>			22b. ADDRESS <u>Albany, Missouri</u>		22c. DATE SIGNED <u>Nov. 2, 59</u>		
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>burial</u>		23b. DATE <u>Nov. 3, 1959</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Miller</u>		23d. LOCATION (City, town, or county) (State) <u>Gentry Co., Missouri</u>		
24. FUNERAL DIRECTOR ADDRESS <u>Clifford Brooks . Albany, Mo.</u>			25. DATE RECD. BY LOCAL REG. <u>Nov. 3 - 1959</u>	26. REGISTRAR'S SIGNATURE <u>Mrs. L. W. Bare</u>			

(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 me or by _____, Student Embalmer No. _____, working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed Donald E. Cochell

Licensed Embalmer No. 4868

P. O. Address Albany, Mo.

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.