

URI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

59-037157

STATE FILE NUMBER

FILED VS. NOV 12 1959

2956

Primary Registration District No. 131

RECEIVED

1. PLACE OF DEATH a. COUNTY <u>PIKE</u> b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>ANNADA</u> Length of stay in this City or Town <u>Years</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MISSOURI</u> b. COUNTY <u>PIKE</u> c. CITY OR TOWN <u>ANNADA</u> Inside Limits 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 checked="" type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>Residence</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	

3. NAME OF DECEASED (Type or print) First <u>FRANK</u> Middle <u>PAULSGROVE</u> Last <u>PAULSGROVE</u>			4. DATE OF DEATH Month <u>Nov.</u> Day <u>8</u> Year <u>1959</u>				
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</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>9/30/90</u>	9. AGE (last birthday) <u>69</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>Farming - SELF - Retired</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Retired</u>		11. BIRTHPLACE (City and state or country) <u>PIKE COUNTY, Mo</u>		12. CITIZEN OF WHAT COUNTRY <u>USA</u>	
13a. FATHER'S NAME <u>JOSEPH PAULSGROVE</u>		13b. MOTHER'S MAIDEN NAME <u>ELIZABETH POOLE</u>		14. NAME OF DECEASED'S WIFE <u>MARGARET PAULSGROVE</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>UNKNOWN</u>		17. INFORMANT Address <u>WIFE - ANNADA, 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>CORONARY OCCLUSION</u> DUE TO (b) _____ Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (c) _____		INTERVAL BETWEEN ONSET AND DEATH <u>1 HR.</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>9-1959</u> to <u>11-8-59</u> and last saw him alive on <u>11-8-59</u> Death occurred at <u>325</u> A-m on the date stated above, and to the best of my knowledge, from the causes stated.					

22a. SIGNATURE (Degree or title) <u>[Signature]</u>			22b. ADDRESS <u>[Address]</u>		22c. DATE SIGNED <u>11/9/59</u>		
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE <u>Nov. 10, 1959</u>		23c. NAME OF CEMETERY OR CREMATORY <u>GREENWOOD</u>		23d. LOCATION (City, town, or county) (State) <u>CLARKSVILLE, Mo</u>	
24. FUNERAL DIRECTOR ADDRESS <u>O. C. Ricks</u> <u>ELSBERRY, Mo</u>			25. DATE RECD. BY LOCAL REG. <u>NOV-10-59</u>		26. REGISTRAR'S SIGNATURE <u>[Signature]</u>		

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

VS DEC 15 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 me
or by _____, Student Embalmer No. _____
working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed *G. G. Gault*

Licensed Embalmer No. 4012
P. O. Address Esleberry, 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.