

DEPARTMENT OF HEALTH - STANDARD CERTIFICATE OF DEATH

59-038714

REGISTRATION DISTRICT NO. 360 PRIMARY REGISTRATION DISTRICT NO. 6225 REGISTRAR'S NO. 168

STATE FILE NUMBER

FILED

OCT 20 1959

1. PLACE OF DEATH a. COUNTY <u>Vernon</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Mo</u> b. COUNTY <u>Jackson</u>							
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Washington Twp.</u>		Length of stay in 1b <u>2yr 1mo 29da</u>		c. CITY OR TOWN <u>Kansas City</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>State Hosp #3 Nevada, Mo</u>			Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>		d. STREET ADDRESS (If outside, give location) <u>2826 Campbell</u>		Reside on Farm Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>				
3. NAME OF DECEASED (Type or print) First <u>Edna</u> Middle <u>Zelenika</u> Last <u>Zelenika</u>				4. DATE OF DEATH Month <u>Oct</u> Day <u>12</u> Year <u>59</u>							
5. SEX <u>F</u>		6. COLOR OR RACE <u>W</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>12/24/06</u>		9. AGE (last birthday) <u>52</u>			
IF UNDER 1 YEAR Months		IF UNDER 24 HR Days		IF UNDER 1 YEAR Hours		IF UNDER 24 HR Min.					
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Dishwasher</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>Restaurant</u>		11. BIRTHPLACE (City and state or country) <u>Joplin Mo.</u>		12. CITIZEN OF WHAT COUNTRY <u>USA</u>				
13a. FATHER'S NAME <u>John E Thompson</u>			13b. MOTHER'S MAIDEN NAME <u>Missouri Emmaline Clark</u>			14. NAME OF HUSBAND OR WIFE <u>unk</u>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>unk</u>			16. SOCIAL SECURITY NO. <u>unk</u>		17. INFORMANT <u>State Hospital Records</u>		Address <u>Nevada, 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>Acute Coronary Occlusion</u> DUE TO (b) <u>Arteriosclerosis</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>5 minutes</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>Chronic Brain Syndrome Associated w/ Convulsive Disorder</u>						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 checked="" 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 _____ Month, Day, Year _____ a.m. _____ p.m. _____		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>7-1-59</u> to <u>10-12-59</u> and last saw her <u>alive</u> on <u>10-12-59</u> Death occurred at <u>5:45 p</u> on the date stated above, and to the best of my knowledge, from the causes stated.											
22a. SIGNATURE (Degree or title) <u>Det Combs M.D.</u>				22b. ADDRESS <u>Nevada Missouri</u>				22c. DATE SIGNED <u>10-12-59</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City, town, or county)		(State)			
<u>BURIAL</u>		<u>OCT 15 1959</u>		<u>OZARK MENI PARK</u>		<u>JOPLIN Mo.</u>					
24. FUNERAL DIRECTOR <u>Hurlbut Glone, Joplin</u>				ADDRESS		25. DATE RECD. BY LOCAL REG. <u>10-16-1959</u>		26. REGISTRAR'S SIGNATURE <u>Anna E. Jarry</u>			

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

(Licensed Embalmer's Statement on Reverse Side)

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 Dale Glover

Licensed Embalmer No. 4593

P. O. Address Joplin

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.