

DURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

FILED VS NOV 24 1959

59-039163

STATE FILE NUMBER

Registration District No. 47 Primary Registration District No. 5169 Registrar's No. 303

1. PLACE OF DEATH a. COUNTY <u>Callaway</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> COUNTY <u>Callaway</u>											
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Nine Mile Prairie Twn Williamsburg Mo</u>		Length of stay in lb <u>Life</u>		c. CITY OR TOWN <u>Williamsburg Mo</u>		Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>									
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>Home</u>			Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>		d. STREET ADDRESS (If outside, give location) <u>none</u>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>								
3. NAME OF DECEASED (Type or print) First <u>Margarette</u> Middle <u>----</u> Last <u>Dade</u>				4. DATE OF DEATH Month <u>II</u> Day <u>20</u> Year <u>1959</u>											
5. SEX <u>Female</u>		6. COLOR OR RACE <u>Colored</u>		7. Married <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>		8. DATE OF BIRTH <u>12-7-1882</u>		9. AGE (last birthday) <u>77</u>		IF UNDER 1 YEAR Months <u> </u> Days <u> </u>		IF UNDER 24 HR Hours <u> </u> Min. <u> </u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Home</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Home</u>		11. BIRTHPLACE (City and state or country) <u>Williamsburg Mo</u>		12. CITIZEN OF WHAT COUNTRY <u>U. S. A</u>							
13a. FATHER'S NAME <u>Louis Dade</u>				13b. MOTHER'S MAIDEN NAME <u>Agnes Smith</u>				14. NAME OF HUSBAND OR WIFE <u>none</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>no</u>		17. INFORMANT Address <u>Edith Muldrow Springfield 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>Death due to natural causes, according</u> DUE TO (b) <u>to the investigation made by</u> DUE TO (c) <u>Denzil C. Browning, Coroner</u>										INTERVAL BETWEEN ONSET AND DEATH					
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 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 <u> </u> a.m. <u> </u> p.m. Month, Day, Year <u> </u>				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>Approx 12 Noon</u> , to <u> </u> and last saw ^{her} / _{him} alive on <u> </u> . Death occurred at <u> </u> m on the date stated above, and to the best of my knowledge, from the causes stated.															
22a. SIGNATURE (Degree or title) <u>Maretta Lawrence, Registrar</u>						22b. ADDRESS <u>Fulton Mo.</u>				22c. DATE SIGNED <u>Nov. 21-1959</u>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE <u>II-24-59</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Johnson Cemetery</u>				23d. LOCATION (City, town, or county) (State) <u>Near Williamsburg Mo</u>							
24. FUNERAL DIRECTOR ADDRESS <u>Carroll's Sons Montgomery City Mo</u>						25. DATE RECD. BY LOCAL REG. <u>Nov. 21-1959</u>		26. REGISTRAR'S SIGNATURE <u>Maretta Lawrence</u>							

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
~~for my~~ on the 21 st Day of November 1959 _____, Student Embalmer No. _____

working under my personal supervision.

Student _____

Signature of Student Embalmer

Signed _____

C. W. Hopkins
C. W. Hopkins

Licensed Embalmer No. I487

Montgomery City Mo

P. O. Address _____

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.