

URI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

FILED VS DEC 15 1959

59-039207

STATE FILE NUMBER

Registration District No. 53 Primary Registration District No. 3010 Registrar's No. 459

ENDED

1. PLACE OF DEATH a. COUNTY <u>Cape Girardeau</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Mo.</u> b. COUNTY <u>BOLLINGER</u>					
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Cape Girardeau</u>		Length of stay in 1b		c. CITY OR TOWN <u>MARQUAND</u>		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>			
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>St. Francis, Hosp.</u>			Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location) <u>(If outside, give location)</u>			Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>James</u> Middle <u>Mouser</u> Last <u></u>				4. DATE OF DEATH Month <u>11</u> Day <u>12</u> Year <u>1959</u>					
5. SEX <u>Male</u>	6. COLOR OR RACE <u>W</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>11-12-59</u>	9. AGE (last birthday)	IF UNDER 1 YEAR Months <u></u> Days <u></u>	IF UNDER 24 HR Hours <u>2</u> Min. <u></u>		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>		11. BIRTHPLACE (City and state or country) <u>Cape Girardeau, Mo.</u>		12. CITIZEN OF WHAT COUNTRY <u>USA</u>		
13a. FATHER'S NAME <u>George Mouser</u>			13b. MOTHER'S MAIDEN NAME <u>Maggie J. Mills</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>None</u>		17. INFORMANT <u>George Mouser, Marquand, Mo.</u> Address <u></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>Prematurity</u>							INTERVAL BETWEEN ONSET AND DEATH <u>4 hours</u>		
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			
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 _____ 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 _____ to _____ and last saw her/him alive on _____ Death occurred at <u>10:40</u> p.m. on the date stated above, and to the best of my knowledge, from the causes stated.									
22a. SIGNATURE (Degree or title) <u>R. M. Foxworth M.D.</u>				22b. ADDRESS <u>24 N. Spring Street Cape Gir., Mo.</u>				22c. DATE SIGNED <u>12/8/59</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE <u>11-14-59</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Liberty Cem.</u>		23d. LOCATION (City, town, or county) <u>Marquand, Mo.</u>			(State)	
24. FUNERAL DIRECTOR <u>Gene Ward Johnson</u> ADDRESS <u></u>				25. DATE RECD. BY LOCAL REG. <u>12-8-59</u>		26. REGISTRAR'S SIGNATURE <u>Gene Kasten</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 R. O. Laird

Licensed Embalmer No. 4538
P. O. Address Jackson, 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.