

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

59-039244

FILED VS DEC 8 1959

53

Registration District No. 0000

Primary Registration District No. 440

STATE FILE NUMBER

RENDERED

1. PLACE OF DEATH a. COUNTY <u>Cape Girardeau</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Cape Girardeau</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Delta</u>		Length of stay in lb <u>71 yrs -</u>	c. CITY OR TOWN <u>Delta</u>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>at home</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <u>_____</u>
Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>			

3. NAME OF DECEASED (Type or print) First <u>CHARLEY</u> Middle <u>SURFACE</u> Last <u>SURFACE</u>			4. DATE OF DEATH Month <u>Nov</u> Day <u>20</u> Year <u>1959</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</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>Sept 12, 1894</u>	9. AGE (last birthday) <u>84</u>	IF UNDER 1 YEAR Months <u>2</u> Days <u>8</u> Hours <u>_____</u> Min. <u>_____</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Farming</u>		11. BIRTHPLACE (City and state or country) <u>Anderson County Ind</u>		
12. CITIZEN OF WHAT COUNTRY <u>USA</u>		13a. FATHER'S NAME <u>Henry Surface</u>		13b. MOTHER'S MAIDEN NAME <u>Martha Davis</u>		
14. NAME OF HUSBAND OR WIFE <u>Rosie Jane Welker</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>Don't know</u>		
17. INFORMANT <u>Shelton Surface</u>		Address <u>Delta, Mo</u>				

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY:			INTERVAL BETWEEN ONSET AND DEATH		
IMMEDIATE CAUSE (a) <u>Medullary Tumor</u>			<u>6 Hours</u>		
DUE TO (b) <u>Cerebral Thrombosis</u>			<u>2 DAYS</u>		
DUE TO (c) <u>Arteriosclerosis</u>			<u>15 Years</u>		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>Congestive Heart Failure</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 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 JULY 1958 to 11-20-59 and last saw him alive on 11-19-59  
 Death occurred at 10:00 A m on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree & title) <u>L. A. Masters D.O. Advance Mo. 11-23-59</u>		22b. ADDRESS		22c. DATE SIGNED	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE <u>Nov. 22, 1959</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Kyunion Cemetery</u>	
23d. LOCATION (City, town, or county) (State) <u>(near) Delta Missouri</u>		24. FUNERAL DIRECTOR <u>Diaphinshoff Funeral Home - Chaff</u>		25. DATE REC'D. BY LOCAL REG. <u>12-1-1959</u>	
26. REGISTRAR'S SIGNATURE <u>Lynn 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

*Jack T. Burnett*

Licensed Embalmer No. 4473

P. O. Address Chaffee, M.

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.