

DEPARTMENT OF HEALTH - STANDARD CERTIFICATE OF DEATH

59-039332

FILED VS. NOV 23 1959

STATE FILE NUMBER

AMENDED

Registration District No. 70 Primary Registration District No. _____ Registrar's No. 57

1. PLACE OF DEATH a. COUNTY <u>Clark</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Mo</u> b. COUNTY <u>Clark</u>			
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Mitchell Koholtz, Mo</u>		Length of stay in 1b		c. CITY OR TOWN <u>Luray Mo</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>Mitchell Nursing Home</u>				Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location) <u>Luray Mo</u>	
3. NAME OF DECEASED (Type or print) First <u>Emma</u> Middle <u>Mae</u> Last <u>Frankhouse</u>				4. DATE OF DEATH Month <u>Nov</u> Day <u>9</u> Year <u>1959</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <u>Sept 6 1876</u>	9. AGE (last birthday) <u>83</u>	IF UNDER 1 YEAR Months <u>4</u> Days <u>3</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>House keeper</u>			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (City and state or country) <u>Hancock County Ill.</u>		
12. CITIZEN OF WHAT COUNTRY <u>United States</u>			13a. FATHER'S NAME <u>Don't know</u>				
13b. MOTHER'S MAIDEN NAME <u>Don't know</u>			14. NAME OF HUSBAND OR WIFE				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)			16. SOCIAL SECURITY NO.		17. INFORMANT Address		
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 circulatory failure</u>						INTERVAL BETWEEN ONSET AND DEATH <u>minutes</u>	
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <u>Coronary thrombosis, myocardial infarction - minor</u>							
DUE TO (c) <u>Advanced arteriosclerosis</u>						<u>Unknown</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 checked="" 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		20g. COUNTY	
20h. STATE							
21. I attended the deceased from <u>7-14-58</u> , to <u>9-10-59</u> and last saw ^{her} <u>alive</u> on <u>11-8-59</u> Death occurred at <u>4:30 P</u> on the date stated above, and to the best of my knowledge, from the causes stated.							
22a. SIGNATURE <u>R.L. Miller</u>			22b. ADDRESS <u>Koholtz Mo</u>		22c. DATE SIGNED <u>11-16-59</u>		
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE <u>Nov. 11, 1959</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Combs Cemetery</u>		23d. LOCATION (City, town, or county) <u>Clark County near Luray Mo</u>	
24. FUNERAL DIRECTOR <u>Guth & Bankos Wyaconda Mo</u>			25. DATE RECD. BY LOCAL REG <u>11-16-59</u>		26. REGISTRAR'S SIGNATURE <u>J.P. Dierges</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 Geo V. Baskett

Licensed Embalmer No. 1817

P. O. Address Wyocono

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.