

URI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

59-040800

FILED VS DEC 4 1959 174

Primary Registration District No. 5644

Registrar's No. 96

STATE FILE NUMBER

ENDED

1. PLACE OF DEATH a. COUNTY <u>LAFAYETTE</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MISSOURI</u> b. COUNTY <u>LAFAYETTE</u>			
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Rural (Lexington Township)</u>		Length of stay in 1b <u>3 DAYS</u>		c. CITY OR TOWN <u>Lexington</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>Goodloe Rest Home</u>			Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>		d. STREET ADDRESS (If outside, give location) <u>R. R. # 2</u>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <u>ELLA</u> Middle <u>MAE</u> Last <u>SALLEE</u>				4. DATE OF DEATH Month <u>November</u> Day <u>16</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 checked="" type="checkbox"/> Divorced <input type="checkbox"/>		8. 7 <u>21-82</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>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>own home</u>		11. BIRTHPLACE (City and state or country) <u>CHILHOWEE, MO.</u>		12. CITIZEN OF WHAT COUNTRY <u>U. S. A</u>	
13a. FATHER'S NAME <u>William Porter</u>		13b. MOTHER'S MAIDEN NAME <u>MARY E. (unknown)</u>		14. NAME OF HUSBAND OR WIFE <u>George W. PAINE (Dec)</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>Wm Paine</u>		Address <u>K. C. 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>Natural Causes</u>						INTERVAL BETWEEN ONSET AND DEATH <u>?</u>	
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.		DUE TO (b) <u>probably Coronary Occlusion</u>					
		DUE TO (c) <u>Found dead on bed at County</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 <u>8 AM</u> a.m. <u> </u> Month, Day, Year <u>11-16-59</u> p.m. <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>after death</u> on <u>11-16-59</u> and last saw her <u>Never</u> alive on <u> </u> Death occurred at <u>8:30 am</u> on the date stated above, and to the best of my knowledge, from the causes stated.							
22a. NAME (Degree or title) <u>W. J. Martin MD Coroner</u>				22b. ADDRESS <u>Oessa Mo</u>		22c. DATE SIGNED <u>11-16-59</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE <u>Nov-18-1959</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Hardin Cemetery</u>		23d. LOCATION (City, town, or county) <u>Hardin Mo.</u>		(State)	
24. FUNERAL DIRECTOR <u>Crunk-Walker</u>			ADDRESS <u>Lexington Mo.</u>		25. DATE RECD. BY LOCAL REG. <u>11-20-59</u>	26. REGISTRAR'S SIGNATURE <u>Monroe [Signature]</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
or by _____, Student Embalmer No. _____
working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed Harold L. Walker

Licensed Embalmer No. 4588

P. O. Address Lexington, Va.

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.