URI DIVISION OF HEALTH – STANDARD CERTIFICATE OF DEATH

FILED VS DEC 2 1959

59-040898

STATE FILE NUMBER

MENDED

Registration District No. 187 Primary Registration District No. 3040 Registrar's No. 276

1. PLACE OF DEATH
a. COUNTY Livingston
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Chillicothe
Length of stay in 1b 2 yr
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Chillicothe Hosp.
Inside Limits Yes ☒ No ☐

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Mo b. COUNTY Chariton
c. CITY OR TOWN Sumner
Inside Limits Yes ☒ No ☐
d. STREET ADDRESS (If outside, give location)
Reside on Farm Yes ☐ No ☐

3. NAME OF DECEASED (Type or print) First: Emma Middle: E. Last: Arnold
4. DATE OF DEATH Month: 11 Day: 30 Year: 59
5. SEX F
6. COLOR OR RACE W.
7. Married ☐ Never Married ☐ Widowed ☒ Divorced ☐
8. DATE OF BIRTH 11-1-1871
9. AGE (last birthday) 88
IF UNDER 1 YEAR: Months Days 24 IF UNDER 24 HR: Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) A Wife
10b. KIND OF BUSINESS OR INDUSTRY Housework
11. BIRTHPLACE (City and state or country) Mt. Auburn Ill
12. CITIZEN OF WHAT COUNTRY USA
13a. FATHER'S NAME Sampson Bottrell
13b. MOTHER'S MAIDEN NAME Elizabeth Dunn
14. NAME OF HUSBAND OR WIFE
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)
16. SOCIAL SECURITY NO. none
17. INFORMANT Mrs Joseph Kaye Address Sumner Mo

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Myocardial Failure
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.
DUE TO (b) Bronchitis
DUE TO (c)
INTERVAL BETWEEN ONSET AND DEATH 2 yr
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. ☐ Yes ☐ No ☐ Unknown
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐
20a. ACCIDENT ☐ SUICIDE ☐ HOMICIDE ☐
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 ☐ NOT WHILE AT WORK ☐
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 Oct 5 6, to Nov 30 59 and last saw her/him alive on
Death occurred at 6:30 Am m on the date stated above, and to the best of my knowledge, from the causes stated.
22a. SIGNATURE J W Vandra (Degree or title) M D
22b. ADDRESS Chillicothe Mo
22c. DATE SIGNED 30 Nov 59
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial
23b. DATE 12-2-59
23c. NAME OF CEMETERY OR CREMATORY Lakeside
23d. LOCATION (City, town, or county) (State) Sumner Mo
24. FUNERAL DIRECTOR S. L. Heipard ADDRESS Mendon Mo
25. DATE RECD. BY LOCAL REG. 11/30/59
26. REGISTRAR'S SIGNATURE Frances B Neill

(Licensed Embalmer's Statement on Reverse Side)

DOCUMENT

BY AFFIDAVIT OF

JAN 8 1960

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by m

or by _____, Student Embalmer No._____

working under my personal supervision.

Student_____ Signed S. L. Leipard

Signature of Student Embalmer

Licensed Embalmer No 3970

P. O. Address Mendon Me

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comp 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.