

VITAL DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

59-041055

RECEIVED **FILED** District of Columbia **15 DEC 1959** 231 Primary Registration District No. **5808** Registrar's No. **600**

STATE FILE NUMBER

1. PLACE OF DEATH a. COUNTY Montgomery b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN _____ Length of stay in 1b 1 Year c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Jonesburg Nursing Home Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Mo b. COUNTY Montgomery c. CITY OR TOWN Bluffton, Mo Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/> d. STREET ADDRESS _____ (If outside, give location) Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>									
3. NAME OF DECEASED (Type or print) First Virgie Middle W Last Brown				4. DATE OF DEATH Month Dec Day 6 Year 1959									
5. SEX F		6. COLOR OR RACE White		7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>		8. DATE OF BIRTH 12-23-1878		9. AGE (last birthday) 80		IF UNDER 1 YEAR Months 11 Days 13		IF UNDER 24 HR Hours _____ Min. _____	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House Wife				10b. KIND OF BUSINESS OR INDUSTRY _____				11. BIRTHPLACE (City and state or country) Americus, Mo		12. CITIZEN OF WHAT COUNTRY U S			
13a. FATHER'S NAME Marquis De Lafayette Benson				13b. MOTHER'S MAIDEN NAME Leannah Jane Moore				14. NAME OF HUSBAND OR WIFE Charles Brown					
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. None				17. INFORMANT Mrs Leannah Jane Vegyelek Address 3817 Po St Louis					
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 Degeneration with Decompensation DUE TO (b) Arteriosclerotic Heart Disease DUE TO (c) _____ Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. _____												INTERVAL BETWEEN ONSET AND DEATH 4 days Several Years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) Generalized arteriosclerosis Senility										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 SUICIDE HOMICIDE <input type="checkbox"/> <input type="checkbox"/> <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 Jan. 7, 1959 to Dec. 6, 1959 and last saw her alive on Dec. 6, 1959 Death occurred at 12:30 p.m. on the date stated above, and to the best of my knowledge, from the causes stated.													
22a. SIGNATURE <i>C. N. Thompson DO</i> (Degree or title)						22b. ADDRESS <i>New Florence Mo</i>			22c. DATE SIGNED 12-8-59				
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 12-9-1959		23c. NAME OF CEMETERY OR CREMATORY Bethany Cemetery				23d. LOCATION (City, town, or county) Bluffton Mo		(State) _____			
24. FUNERAL DIRECTOR Baker Funeral Home New Florence, Mo ADDRESS _____				25. DATE RECD. BY LOCAL REG. 12-8-1959		26. REGISTRAR'S SIGNATURE <i>Laura B. Callaway</i>							

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

JAN 21 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 me
or by _____, Student Embalmer No. _____
working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed OB Baker

Licensed Embalmer No. 3375

P. O. Address New Florence, 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.