

JURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

59-043175

FILED VS NOV 23 1959

373

Registration District No. 6265 Registrar's No. 48

STATE FILE NUMBER

| | | | | | | | | | | | |
|---|--|---|---|---|--|--|---|--|-------------------------------------|---|--|
| 1. PLACE OF DEATH a. COUNTY WEBSTER | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MO b. COUNTY WEBSTER | | | | | | | |
| b. CITY (If outside corporate limits, give TOWNSHIP only) GRANT | | Length of stay in 1b 3 MO | | c. CITY OR TOWN MARSHFIELD R2 | | Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> | | | | | |
| c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION | | | Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/> | | d. STREET ADDRESS (If outside, give location) JMI WEST | | Reside on Farm Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> | | | | |
| 3. NAME OF DECEASED (Type or print) JOHN ELMER ALEXANDER | | | | 4. DATE OF DEATH Month NOV Day 11 Year 1959 | | | | | | | |
| 5. SEX MALE | | 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 12-20-1885 | | 9. AGE (last birthday) 73 | | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RET FARMER | | 10b. KIND OF BUSINESS OR INDUSTRY — | | 11. BIRTHPLACE (City and state or country) MISSOURI | | 12. CITIZEN OF WHAT COUNTRY U.S.A | | IF UNDER 1 YEAR Months Days Hours Min. | | | |
| 13a. FATHER'S NAME THOMAS ALEXANDER | | | 13b. MOTHER'S MAIDEN NAME FLORENTINE CHANDLER | | | 14. NAME OF HUSBAND OR WIFE HERSCHEL ALEXANDER MARSHFIELD | | | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) NO | | | | 16. SOCIAL SECURITY NO. — | | 17. INFORMANT HERSCHEL ALEXANDER MARSHFIELD | | | 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) MEDULLARY PARALYSIS DUE TO (b) CEREBRAL THROMBOSIS DUE TO (c) ARTERIO SCLEROSIS 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 type="checkbox"/> No <input type="checkbox"/> Unknown | | | | | | | | INTERVAL BETWEEN ONSET AND DEATH | | | |
| 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 2-27-58 to 11/11/59 and last saw ^{her} him alive on 11/11/59 Death occurred at 345 A.M. on the date stated above, and to the best of my knowledge, from the causes stated. | | | | | | | | | | | |
| 22a. SIGNATURE <i>[Signature]</i> | | | | | | 22b. ADDRESS Marshfield, Mo. | | | 22c. DATE SIGNED 11/14/59 | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL | | 23b. DATE 11-14-1959 | | 23c. NAME OF CEMETERY OR CREMATORY BLACK OAK | | 23d. LOCATION (City, town, or county) (State) WEBSTER CO MO | | | | | |
| 24. FUNERAL DIRECTOR BARBER-EDWARDS MARSHFIELD | | | | | | ADDRESS | | 25. DATE RECD. BY LOCAL REG. NOV 16 1959 | | 26. REGISTRAR'S SIGNATURE <i>[Signature]</i> | |

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 _____



Licensed Embalmer No. _____

384

P. O. Address _____



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.