URI DIVISION OF HEALTH – STANDARD CERTIFICATE OF DEATH

'59 046502

FILED VS DEC 29 1959

Registration District No. 325 Primary Registration District No. 4480 Registrar's No. ~~4480~~ STATE FILE NUMBER 48

ENDED

1. PLACE OF DEATH
a. COUNTY Schuyler
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Greentop — Length of stay in 1b
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Greentop Nursing Home — Inside Limits Yes [X] No [ ]

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Mo. b. COUNTY Adair
c. CITY OR TOWN Kirksville — Inside Limits Yes [X] No [ ]
d. STREET ADDRESS (If outside, give location) 810 S. Marion — Reside on Farm Yes [ ] No [X]

3. NAME OF DECEASED (Type or print) First Minnie Middle J, Last Wellborn

4. DATE OF DEATH Month Day Year Dec. 20, 1959

5. SEX F
6. COLOR OR RACE W
7. Married [X] Never Married [ ] Widowed [X] Divorced [ ]
8. DATE OF BIRTH 1/2/1871
9. AGE (last birthday) 88 — IF UNDER 1 YEAR Months Days — IF UNDER 24 HR Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Home
10b. KIND OF BUSINESS OR INDUSTRY Home
11. BIRTHPLACE (City and state or country) Lee County, Iowa
12. CITIZEN OF WHAT COUNTRY U. S. A.

13a. FATHER'S NAME James Jefferson Huffman
13b. MOTHER'S MAIDEN NAME Serilda Van Horn
14. NAME OF HUSBAND OR WIFE Newton J. Wellborn

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service) X
16. SOCIAL SECURITY NO. ——
17. INFORMANT Address Mr. Chester E. Wellborn, Kirksville, Mo.

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY: — INTERVAL BETWEEN ONSET AND DEATH

IMMEDIATE CAUSE (a) Medullary failure

Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.
DUE TO (b) Cerebral anoxia
DUE TO (c) Cerebral thrombosis

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 [X]
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. 4, '59 Dec. 20, '59 and last saw her/him alive on Dec. 20, 1959
Death occurred at 4:40 P m on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) Frank Brist DO
22b. ADDRESS P.O. Box 235 Greentop Mo
22c. DATE SIGNED 12-21-59

23a. BURIAL, CREMATION, REMOVAL (Specify) Burial
23b. DATE 12/22/59
23c. NAME OF CEMETERY OR CREMATORY Fort Madison Cemetery
23d. LOCATION (City, town, or county) (State) Adair County, Mo.

24. FUNERAL DIRECTOR Paul M. Riley ADDRESS Kirksville, Mo.
25. DATE RECD. BY LOCAL REG. 12-22-59
26. REGISTRAR'S SIGNATURE Mrs. Art Drake

(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 m

or by _____, Student Embalmer No._____

working under my personal supervision.

Student_____ Signed George W. Davall

Signature of Student Embalmer

Licensed Embalmer No. 4799

P. O. Address Kirksville,

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.