

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-63-020719

STATE FILE NUMBER

Registration District No. 187 Primary Registration District No. 3040 Registrar's No. 128

DO NOT WRITE ON THIS STUB

AMENDED

VS 300
Rev. 4/59

10595
205902

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DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

INSTEAD OF

SHOULD READ

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

FILED MAY 27 1963

1. PLACE OF DEATH
a. COUNTY Livingston
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Chillicothe Length of stay in 1b. 7 Years
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Susan's Rest Home 505 Second Inside Limits Yes No

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

3. NAME OF DECEASED (Type or print) First Jennie Middle Emley Last Emley
4. DATE OF DEATH Month May Day 19 Year 1963

5. SEX Female 6. COLOR OR RACE White 7. Married Never Married Widowed Divorced 8. DATE OF BIRTH 12/8/1869 9. AGE (last birthday) 93 IF UNDER 1 YEAR Months 5 Days 11 IF UNDER 24 HR Hours ✓ Min. ✓

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

13a. FATHER'S NAME Charles W. Emley 13b. MOTHER'S MAIDEN NAME Deliah Creager 14. NAME OF HUSBAND OR WIFE None

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of No) 17. INFORMANT Mr. Robert Nargone Chula Mo Address Chula Mo

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Chronic myocarditis
DUE TO (b) arteriosclerosis
DUE TO (c) _____
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.

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 12:00 to 2:19-63 and last saw her alive on 4-28-63
Death occurred at 8:00 A.M. on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) Joseph F. Gale M.D. 22b. ADDRESS Chillicothe Mo 22c. DATE SIGNED 5-20-63

23a. BURIAL, CREMATION, REMOVAL (Specify) Burial 23b. DATE 5/21/1963 23c. NAME OF CEMETERY OR CREMATORY May Cemetery 23d. LOCATION (City, town, or county) (State) Chula Missouri

24. FUNERAL DIRECTOR E.J. Robertson Funeral Home - Chula Mo ADDRESS Chula Mo 25. DATE RECD. BY LOCAL REG. May 24, 1963 26. REGISTRAR'S SIGNATURE Annalee Taylor

USE BLACK INK OR TYPEWRITER RIBBON

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

J. Robertson

Licensed Embalmer No. _____

4388

P. O. Address _____

Laredo

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.