MISSOURI DIVISION OF HEALTH – STANDARD CERTIFICATE OF DEATH

-61-026475
STATE FILE NUMBER

Registration District No. 316 Primary Registration District No. — Registrar's No. 244

AMENDED

FILED JUN 28 1961

1. PLACE OF DEATH
a. COUNTY: St. Francois
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN: St. Francois Twp. Farmington -rural
Length of stay in this place: 4 day's
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION: Osteopathic Hospital
Inside Limits: Yes ☐ No ☒

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

3. NAME OF DECEASED (Type or print): First: Mattie Middle: Alice Last: Jarrell
4. DATE OF DEATH: Month: June Day: 22nd Year: 1961
5. SEX: Female
6. COLOR OR RACE: White
7. Married ☐ Never Married ☐ Widowed ☒ Divorced ☐
8. DATE OF BIRTH: Apr. 9, 1874
9. AGE (last birthday): 87
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): Housewife
10b. KIND OF BUSINESS OR INDUSTRY: Home
11. BIRTHPLACE (City and state or country): St. Francois Co, Mo
12. CITIZEN OF WHAT COUNTRY: U S A
13a. FATHER'S NAME: Franklin Wells
13b. MOTHER'S MAIDEN NAME: Susan Hilton
14. NAME OF HUSBAND OR WIFE: Deceased
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 Address: Mrs. Ben Christopher, Desloge, 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): Cerebal anoxia — INTERVAL BETWEEN ONSET AND DEATH: 10 days
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.
DUE TO (b): Cerebal atherosclerosis — several months
DUE TO (c): General arteriosclerosis — years
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 ☐ ☒
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 6/19/61 to 6/22/61 and last saw her alive on 6/22/61
Death occurred at 1:Pm on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE: W A Rudloff (Degree or title) MD
22b. ADDRESS: Flat River Mo
22c. DATE SIGNED: 6/23/61

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE: 6/25/1961
23c. NAME OF CEMETERY OR CREMATORY: Parkview
23d. LOCATION (City, town, or county) (State): Farmington, Mo.

24. FUNERAL DIRECTOR ADDRESS: C.Z.Boyer & Son, Inc. Desloge, Mo
25. DATE RECD. BY LOCAL REG.: June 24, 1961
26. REGISTRAR'S SIGNATURE: Esther Rudloff

(Licensed Embalmer's Statement on Reverse Side)

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

ITEM NO.	SHOULD READ	INSTEAD OF	DATE AMENDED
9			
10			
10			
X			

BY AFFIDAVIT OF DOCUMENT

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 L. T. Boyer

Licensed Embalmer No. 3660

P. O. Address Leesburg Ga

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.