

MICHIGAN DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

59-028926

FILED VS. SEP 1 1959 144

Registration District No. _____ Primary Registration District No. 4233 Registrar's No. 81

STATE FILE NUMBER

1. PLACE OF DEATH a. COUNTY <u>Iron</u> b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Arcadia</u> Length of stay in 1b <u>7 Days</u> c. FULL NAME OF (if NOT in hospital, give location) HOSPITAL OR INSTITUTION _____ Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Mo</u> b. COUNTY <u>Franklin</u> c. CITY OR TOWN <u>Lonedell 6 Mi N East</u> Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> d. STREET ADDRESS _____ (If outside, give location) Reside on Farm Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>JOSEPH WILLIAM WHITTAKER</u>			4. DATE OF DEATH Month Day Year <u>8 23 1959</u>				
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <u>12/18/76</u>	9. AGE (last birthday) <u>82</u>	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) <u>Machinist</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Tool & Die</u>		11. BIRTHPLACE (City and state or country) <u>Camelton, Ind</u>		12. CITIZEN OF WHAT COUNTRY <u>USA</u>	
13a. FATHER'S NAME <u>THOMAS WHITTAKER</u>			13b. MOTHER'S MAIDEN NAME <u>ELIZABETH Mc CUTCHEON</u>			14. NAME OF HUSBAND OR WIFE <u>LAURA WHITTAKER</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>no</u>			16. SOCIAL SECURITY NO. _____		17. INFORMANT Address <u>Mrs Martha Freegard Arcadia, Mo</u>		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Arteriosclerotic heart disease.</u> INTERVAL BETWEEN ONSET AND DEATH <u>1 year</u> DUE TO (b) _____ Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (c) _____							
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							
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 <u>8-18-59</u> to <u>8-23-59</u> and last saw <u>her</u> alive on <u>8-23-59</u> Death occurred at <u>2.15 P.M.</u> on the date stated above, and to the best of my knowledge, from the causes stated.							
22a. SIGNATURE (Degree or title) <u>Marvin C. Menne M.D.</u>				22b. ADDRESS <u>109 N. Main, Ironton, Missouri</u>		22c. DATE SIGNED <u>8-24-59</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE <u>8-24-59</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Calvary Cemetery</u>		23d. LOCATION (City, town, or county) (State) <u>Robertsville Mo.</u>	
24. FUNERAL DIRECTOR <u>White Funeral Home, Ironton, Mo.</u>				25. DATE RECD. BY LOCAL REG. <u>8-24-59</u>		26. REGISTRAR'S SIGNATURE <u>Mrs Aris Jones</u>	

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

SEP 2 1958

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by _____
or by _____, Student Embalmer No. _____
working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed Garcel White

Licensed Embalmer No. 3012

P. O. Address Orator

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.