

URI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

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STATE FILE NUMBER

Registration District No. _____ Primary Registration District No. 3017 Registrar's No. 190

1. PLACE OF DEATH a. COUNTY Cooper				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Mo. b. COUNTY Cooper					
b. CITY (If outside corporate limits, give TOWNSHIP only) Boonville		Length of stay in 1b 23 yrs		c. CITY OR TOWN Boonville		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>			
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION 514 Main			Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location) 514 Main		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First DOROTHY Middle KATHRYN Last DELUDE				4. DATE OF DEATH Month Dec. Day 29 Year 1959					
5. SEX female	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 8/29/99	9. AGE (last birthday) 60	IF UNDER 1 YEAR Months _____ Days _____	IF UNDER 24 HR Hours _____ Min. _____		
10a. USUAL OCCUPATION (Give kind of work done during life, even if retired) housewife			10b. KIND OF BUSINESS OR INDUSTRY home		11. BIRTHPLACE (City and state or country) Missouri		12. CITIZEN OF WHAT COUNTRY USA		
13a. FATHER'S NAME W. G. Holt			13b. MOTHER'S MAIDEN NAME Margaret H. Wells			14. NAME OF HUSBAND OR WIFE Harold E. Delude			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, unknown) (If yes, give war or dates of service) no			16. SOCIAL SECURITY NO. unknown		17. INFORMANT W. G. Holt			Address Boonville, 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) Shock							INTERVAL BETWEEN ONSET AND DEATH Inst.		
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) HUSBANDS DEATH									
DUE TO (c) _____									
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) PARAPLEGIA 3 yrs standing. Essential hypertension						PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input checked="" 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 1945 to Dec 29-59 and last saw her him alive on 12/28/59 Death occurred at 5:15 P m on the date stated above, and to the best of my knowledge, from the causes stated.									
22a. SIGNATURE (Degree or title) M. K. DeGraef M.D.				22b. ADDRESS Boonville Mo				22c. DATE SIGNED 12/30/59	
23a. BURIAL, CREMATION, REINTERMENT (Specify) burial		23b. DATE 1/1/60	23c. NAME OF CEMETERY OR CREMATORY Walnut Grove Cem.		23d. LOCATION (City, town, or county) Boonville, Mo.				
24. FUNERAL DIRECTOR B. W. Thacher			ADDRESS Boonville, Mo.		25. DATE RECD. BY LOCAL REG. 12/31/59		26. REGISTRAR'S SIGNATURE D. Hooper		

(Licensed Embalmer's Statement on Reverse Side)

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

JAN 2 1987

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 Berry W. Shaker

Licensed Embalmer No. 3944

P. O. Address Bronville

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.