

URI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

FILED VS JAN - 4 1960

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STATE FILE NUMBER

Registration District No. 322 Primary Registration District No. 6087 Registrar's No. 15

ENDED

1. PLACE OF DEATH a. COUNTY <u>Saline</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Mo</u> b. COUNTY <u>Saline</u>				
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Cambridge</u>		Length of stay in 1b		c. CITY OR TOWN <u>Gilliam</u>		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>		
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>2 Miles N Gilliam, M.</u>			Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>		d. STREET ADDRESS (If outside, give location) <u>2 Miles N Gilliam</u>		Reside on Farm Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Wallace</u> Middle <u>Newton</u> Last <u>Tillman</u>				4. DATE OF DEATH Month <u>December</u> Day <u>31</u> Year <u>1959</u>				
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>		8. DATE OF BIRTH <u>11-21-1900</u>	9. AGE (last birthday) <u>59</u>	IF UNDER 1 YEAR Months <u> </u> Days <u> </u>	IF UNDER 24 HR Hours <u> </u> Min. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Laborer</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>Farm</u>		11. BIRTHPLACE (City and state or country) <u>Saline County, Mo.</u>		12. CITIZEN OF WHAT COUNTRY <u>USA</u>	
13a. FATHER'S NAME <u>William L. Tillman</u>			13b. MOTHER'S MAIDEN NAME <u>Frances Campbell</u>			14. NAME OF HUSBAND OR WIFE <u>None</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. <u>none</u>		17. INFORMANT Address <u>Mrs Nellie Stanley Mendon, 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>Suffocation, from smoke</u>							INTERVAL BETWEEN ONSET AND DEATH <u>4 hrs</u>	
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <u>Bed cloths caught fire from</u>								
DUE TO (c) <u>Smoking Cigarette.</u>								
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 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 <u> </u> Month, Day, Year <u> </u>								
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>Investigation Jan 15, 1960</u> and last saw her <u> </u> alive on <u> </u> . Death occurred at <u>10 p.m. Dec. 31, 1959</u> the date stated above, and to the best of my knowledge, from the causes stated.								
22a. SIGNATURE (Degree or title) <u>D. L. Lawrence M.D. Coroner Saline Co</u>				22b. ADDRESS <u>Marshall Mo.</u>			22c. DATE SIGNED <u>1-1-60</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE <u>January 3 1960</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Indian Grove</u>		23d. LOCATION (City, town, or county) <u>Brunswick</u>		STATE <u>Mo.</u>		
24. FUNERAL DIRECTOR <u>Haines Funeral Home Slater, Mo.</u>			25. DATE RECD. BY LOCAL REG. <u>1/2/1960</u>		26. REGISTRAR'S SIGNATURE <u>Mrs. Raymond Brame</u>			

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 me
or by _____, Student Embalmer No. _____
working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed Walter J. Daines, J.

Licensed Embalmer No. 4557

P. O. Address Slater, Pa.

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.