

DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

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FILED VS. FEB 15 1960

1 Primary Registration District No. 3000 Registrar's No. 26

STATE FILE NUMBER

1. PLACE OF DEATH a. COUNTY Adair				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY Sullivan									
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Kirksville		Length of stay in 1b 6 Weeks		c. CITY OR TOWN Green City		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>							
c. FULL NAME OF (IF NOT in hospital, give location) HOSPITAL OR INSTITUTION Laughlin Hospital			Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location) No street address		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>						
3. NAME OF DECEASED (Type or print) Estella Gladice Graham				4. DATE OF DEATH Feb. 5, 1960									
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 8/10/1883		9. AGE (last birthday) 76		IF UNDER 1 YEAR Months Days Hours Min.		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 Farm home		11. BIRTHPLACE (City and state or country) Martinstown, Mo.			12. CITIZEN OF WHAT COUNTRY USA				
13a. FATHER'S NAME William Hodges				13b. MOTHER'S MAIDEN NAME Lucy Draper			14. NAME OF HUSBAND OR WIFE Lewis Graham						
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. None		17. INFORMANT Lano Cassady, Worthington, Mo. Address							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hypostatic pneumonia DUE TO (b) Gastric hemorrhage DUE TO (c) Garcinoma of Stomach Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.										INTERVAL BETWEEN ONSET AND DEATH 3 days 3 weeks ?			
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.		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 12/28/59 to 2/5/60 and last saw her 2/4/60 Death occurred at 8:03 A.m. on the date stated above, and to the best of my knowledge, from the causes stated.													
22a. SIGNATURE (Degree or title) <i>W.D.M. Chase D.D.</i>					22b. ADDRESS 711-W-Jefferson St. Kirksville, Missouri			22c. DATE SIGNED 1-8-1960					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE Feb. 7, 1960		23c. NAME OF CEMETERY OR CREMATORY Mt. Olivet Cemetery Green City, Mo			23d. LOCATION (City, town, or county) (State)						
24. FUNERAL DIRECTOR Blenn E. Kent Green City, Mo.					25. DATE RECD. BY LOCAL REG. 2-10-1960		26. REGISTRAR'S SIGNATURE <i>Dorner W. Raliff</i>						

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

H. D. McCLURE, D.D.

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 Karl R. Kent

Licensed Embalmer No. 4689

P. O. Address Green City

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.