

FRI, DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

=60-000029

FILED VS FEB 8 1960

Registration District No. 1 Primary Registration District No. 3000 Registrar's No. 20

STATE FILE NUMBER

1. PLACE OF DEATH a. COUNTY Adair				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Mo. b. COUNTY Adair					
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Kirksville		Length of stay in 1b 12 Hours		c. CITY OR TOWN Kirksville		Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>			
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Stickler			Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location) Route 5		Reside on Farm Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First Meda Middle May Last Watson				4. DATE OF DEATH Month Jan. Day 31 Year 1960					
5. SEX F	6. COLOR OR RACE White	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>		8. DATE OF BIRTH 4/28 1908	9. AGE (last birthday) 51	IF UNDER 1 YEAR Months	IF UNDER 24 HR Days Hours Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housework			10b. KIND OF BUSINESS OR INDUSTRY Own Home		11. BIRTHPLACE (City and state or country) Adair County		12. CITIZEN OF WHAT COUNTRY U.S.		
13a. FATHER'S NAME Lorenzo Gunning			13b. MOTHER'S MAIDEN NAME Edith Herrin			14. NAME OF HUSBAND at time Melvin Watson			
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 Melvin Watson Kirksville, 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) Myocarditis, acute							INTERVAL BETWEEN ONSET AND DEATH 12 hrs.		
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. } DUE TO (b) Hypertension							2 months		
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 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 Dec. 28, 1959 to Jan. 31, 1960 and last saw her her alive on Jan. 31, 1960 Death occurred at 2:15 a.m. on the date stated above, and to the best of my knowledge, from the causes stated.									
22a. SIGNATURE (Degree or title) <i>Robert Stickler MD</i>				22b. ADDRESS <i>Kirksville Mo</i>			22c. DATE SIGNED <i>2-2-60</i>		
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE	23c. NAME OF CEMETERY OR CREMATORY			23d. LOCATION (City, town, or county) (State)			
Burial		Feb. 2, 1960	Sabbath Home Cem.			Adair County Mo.			
24. FUNERAL DIRECTOR ADDRESS <i>Foster Memorial Home, Kirksville, Mo.</i>				25. DATE RECD. BY LOCAL REG. <i>2-2-1960</i>		26. REGISTRAR'S SIGNATURE <i>Doris W. Ratliff</i>			

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

R. O. STICKLER, M.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 Novak E. Foster

Licensed Embalmer No. 4742

P. O. Address Fukerill

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.