

RI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-60-000054

FILED VS. JAN 15 1960

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Primary Registration District No. 3002

Registrar's No. 4

STATE FILE NUMBER

1. PLACE OF DEATH a. COUNTY <b>Audrain</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Mo.</b> b. COUNTY <b>Audrain</b>				
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>Mexico</b>		Length of stay in 1b <b>2 Mo.</b>		c. CITY OR TOWN <b>Benton City</b>		Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>		
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>Audrain Hospital</b>			Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location) <b>Route # 1</b>		Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>John</b> Middle <b>Thomas</b> Last <b>ERWIN</b>			4. DATE OF DEATH Month <b>Jan</b> Day <b>5</b> Year <b>1960</b>					
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>		8. DATE OF BIRTH <b>1-22-75</b>	9. AGE (last birthday) <b>84</b>	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Farmer</b>			10b. KIND OF BUSINESS OR INDUSTRY <b>Farming</b>		11. BIRTHPLACE (City and state or country) <b>Callaway Co., Mo.</b>		12. CITIZEN OF WHAT COUNTRY <b>U. S. A.</b>	
13a. FATHER'S NAME <b>John Sullivan Erwin</b>			13b. MOTHER'S MAIDEN NAME <b>Martha Va. Oxley</b>			14. NAME OF HUSBAND OR WIFE <b>Effie Simpson Erwin</b>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>			16. SOCIAL SECURITY NO. <b>None</b>		17. INFORMANT Address <b>Mrs. Effie Erwin Benton City, Mo.</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral thrombosis</b> DUE TO (b) <b>Cerebral arteriosclerosis</b> DUE TO (c) _____ Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.							INTERVAL BETWEEN ONSET AND DEATH <b>38 days</b> <b>10 yrs</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a). <b>Cerebral arterial disease.</b>					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 <b>11-30-59</b> to <b>1-5-60</b> and last saw <sup>her</sup> him alive on <b>1-5-60</b> Death occurred at <b>11:58 P.M.</b> m on the date stated above, and to the best of my knowledge, from the causes stated.								
22a. SIGNATURE (Dee or title) <b>E. Kellmback M.D.</b>				22b. ADDRESS <b>Mexico, Mo.</b>			22c. DATE SIGNED <b>1-7-60</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE <b>1-8-1960</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Liberty Christian</b>		23d. LOCATION (City, town, or county) <b>Callaway County, Mo.</b>		(State)	
24. FUNERAL DIRECTOR <b>Arnold Funeral Home Mexico, Mo.</b>				25. DATE RECD. BY LOCAL REG. <b>Jan. 7-1960</b>		26. REGISTRAR'S SIGNATURE <b>Blanche Neely</b>		

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 \_\_\_\_\_, Student Embalmer No. \_\_\_\_\_ or by \_\_\_\_\_, Student Embalmer No. \_\_\_\_\_ working under my personal supervision.

Student \_\_\_\_\_  
Signature of Student Embalmer

Signed *Ray Miller*

Licensed Embalmer No. 449

P. O. Address Medic

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.