

RI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

=60-000072

FILED VS JAN 22 1960

Registration District No. 10 Primary Registration District No. 3002 Registrar's No. 14

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> COUNTY <b>Montgomery</b>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>Mexico Mo</b>		Length of stay in 1b <b>2 Days</b>	c. CITY OR TOWN <b>New Florence, Mo</b>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>Audrain</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <b>Reside on Farm</b> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>

3. NAME OF DECEASED (Type or print) First <b>Willard</b> Middle <b>Poston</b> Last <b>Poston</b>			4. DATE OF DEATH Month <b>1</b> Day <b>16</b> Year <b>1960</b>	
5. SEX <b>M</b>	6. COLOR OR RACE <b>White</b>	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <b>10-8-1884</b>	9. AGE (last birthday) <b>75</b>
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	11. BIRTHPLACE (City and state or country) <b>Linn, Mo</b>	12. CITIZEN OF WHAT COUNTRY <b>U S</b>
13a. FATHER'S NAME <b>Robert Poston</b>		13b. MOTHER'S MAIDEN NAME <b>Addie Bess</b>		14. NAME OF HUSBAND OR WIFE <b>Myrtle Poston</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>489-16-3800</b>	17. INFORMANT Address <b>Mrs Jewell Johnson New Florence, 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>Diabetic Coma</b>		INTERVAL BETWEEN ONSET AND DEATH <b>48 hrs.</b>	
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) <b>Diabetes Mellitus</b>		Interval between onset and death <b>Unknown</b>
	DUE TO (c)		

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <b>Diabetic Gangrene of right foot leg.</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	
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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 <input type="checkbox"/> a.m. <input type="checkbox"/> 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 ~~1-14-60~~ **1-14-60** to **1-16-60** and last saw him alive on **1-15-60**  
Death occurred at **3:30 A.M.** on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE <b>W.D. Swan</b>	(Degree or title) <b>MD</b>	22b. ADDRESS <b>Greep, Mo</b>	22c. DATE SIGNED <b>1-16-60</b>
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23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE <b>1-16-60</b>	23c. NAME OF CEMETERY OR CREMATORY <b>St James Cemetery</b>	23d. LOCATION (City, town, or county) (State) <b>Big Spring Mo</b>
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24. FUNERAL DIRECTOR <b>Ba ker Funeral Home New Florence, Mo</b>	ADDRESS	25. DATE RECD. BY LOCAL REG. <b>Jan 16-1960</b>	26. REGISTRAR'S SIGNATURE <b>Blanche Neely</b>
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(Licensed Embalmer's Statement on Reverse Side)

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 D B Baker

Licensed Embalmer No. 3375

P. O. Address New Florence, Mo

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.