

# RI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-60-000105

FILED VS FEB 4 1960 11

Registration District No. \_\_\_\_\_ Primary Registration District No. 4024 Registrar's No. 6 STATE FILE NUMBER \_\_\_\_\_

DED

1. PLACE OF DEATH a. COUNTY <b>BARRY</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MISSOURI</b> b. COUNTY <b>BARRY</b>				
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>CASSVILLE</b>			Length of stay in 1b		c. CITY OR TOWN <b>CASSVILLE</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION				Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location)		Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <b>ALLEN</b> Middle <b>HENRY</b> Last <b>HENRY</b>				4. DATE OF DEATH Month <b>JANUARY</b> Day <b>14</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>1-14-70</b>	9. AGE (last birthday) <b>90</b>	IF UNDER 1 YEAR Months _____ Days _____	IF UNDER 24 HR 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>Farm</b>		11. BIRTHPLACE (City and state or country) <b>Ireland</b>		12. CITIZEN OF WHAT COUNTRY <b>U? S. A.</b>	
13a. FATHER'S NAME <b>Unknown</b>			13b. MOTHER'S MAIDEN NAME <b>Unknown</b>			14. NAME OF HUSBAND OR WIFE <b>Anna Barry Henry</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 <b>John Allen, Wynona, Oklahoma</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>Heart disease</b>							INTERVAL BETWEEN ONSET AND DEATH	
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (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)						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>1-1-</b> to <b>1-12</b> and last saw <sup>her</sup> him alive on <b>1-12-60</b> Death occurred at <b>8:15</b> p.m. on the date stated above, and to the best of my knowledge, from the causes stated.								
22a. SIGNATURE <i>Bern H. Dalys</i> (Degree or title)				22b. ADDRESS <b>Cassville, Missouri</b>		22c. DATE SIGNED <b>1-18-60</b>		
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE <b>1-17-60</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Horner Cem.</b>		23d. LOCATION (City, town, or county) (State) <b>Barry County, Missouri</b>				
24. FUNERAL DIRECTOR <b>Paul D. Henbest, Cassville, Mo.</b> ADDRESS				25. DATE RECD. BY LOCAL REG. <b>1-25-60</b>		26. REGISTRAR'S SIGNATURE <i>Grace Williams</i>		

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

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

Signed Margaret C. Herbert

Licensed Embalmer No. 4389

P. O. Address Cassville,

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.