

RI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

60-000107

FILED VS FEB 4 1960

4624

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STATE FILE NUMBER

Registration District No. / Primary Registration District No. Registrar's No.

|  |   |   |  |   |  |   |   |  |
|--|---|---|--|---|--|---|---|--|
| 1. PLACE OF DEATH<br>a. COUNTY <b>Barry</b>  |   |   |  | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <b>Missouri</b> COUNTY <b>Barry</b> |  |   |   |  |
| b. CITY (if outside corporate limits, give TOWNSHIP only)<br>OR TOWN <b>Cassville</b>  |   | Length of stay in 1b<br><b>5 days</b>   |  | c. CITY OR TOWN   |  | Inside Limits<br>Yes <input type="checkbox"/> No <input type="checkbox"/> |   |  |
| c. FULL NAME OF (if NOT in hospital, give location)<br>HOSPITAL OR INSTITUTION <b>Cassville Community Hosp</b>   |   |   | Inside Limits<br>Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>         |   | d. STREET ADDRESS (If outside, give location)<br><b>Exeter, Mo. Rural</b>  |   | Reside on Farm<br>Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> |  |
| 3. NAME OF DECEASED (Type or print)<br>First <b>Eldie</b> Middle <b>Jane</b> Last <b>Lee</b>   |   |   |  | 4. DATE OF DEATH<br>Month <b>January</b> Day <b>17</b> Year <b>1960</b>   |  |   |   |  |
| 5. SEX<br><b>Female</b>  | 6. COLOR OR RACE<br><b>White</b>  | 7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/><br>Widowed <input type="checkbox"/> Divorced <input type="checkbox"/> |  | 8. DATE OF BIRTH<br><b>8-9-1890</b>   | 9. AGE (last birthday)<br><b>69</b>  | IF UNDER 1 YEAR<br>Months <b>5</b> Days <b>8</b>                          | IF UNDER 24 HR<br>Hours <b></b> Min. <b></b>  |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Housewife</b>  |   | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>Housewife</b>   |  | 11. BIRTHPLACE (City and state or country)<br><b>Berryville Arkansas</b>  |  | 12. CITIZEN OF WHAT COUNTRY<br><b>USA</b>                                 |   |  |
| 13a. FATHER'S NAME<br><b>Samuel Woods</b>  |   |   | 13b. MOTHER'S MAIDEN NAME<br><b>Sarah Evaline Turner</b>                                     |   | 14. NAME OF HUSBAND OR WIFE<br><b>Walter Clay Lee</b>  |   |   |  |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)<br><b>No</b>  |   | 16. SOCIAL SECURITY NO.<br><b>None</b>  |  | 17. INFORMANT Address<br><b>Walter Clay Lee Exeter, Mo. R#</b>  |  |   |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Coronary Thrombosis</b><br>DUE TO (b) <b>Arteriosclerotic Heart Disease</b><br>DUE TO (c) <b></b><br>Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. |   |   |  |   |  | INTERVAL BETWEEN ONSET AND DEATH<br><b>40 min</b><br><b>Unknown</b>       |   |  |
| 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.<br><input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown |   |   |  |
| 19. WAS AUTOPSY PERFORMED?<br>YES <input type="checkbox"/> NO <input 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<br>Hour <b></b> a.m. <b></b> p.m.<br>Month, Day, Year <b></b>  |   |   |  |   |  |   |   |  |
| 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>1-14-60</b> to <b>1-17-60</b> and last saw her <b>him</b> alive on <b>1-17-60</b><br>Death occurred at <b>6:23 P.M.</b> on the date stated above, and to the best of my knowledge, from the causes stated.   |   |   |  |   |  |   |   |  |
| 22. SIGNATURE (Degree or title)<br><b>Grace E. Widling, D.O.</b>   |   |   |  | 23. ADDRESS<br><b>Cassville, Mo.</b>  |  |   | 22c. DATE SIGNED<br><b>1-19-60</b>  |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>   | 23b. DATE<br><b>1-21-60</b>   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Chitwood Cem.</b>  |  | 23d. LOCATION (City, town, or county) (State)<br><b>2 Mi. S. Wheaton, Mo.</b>   |  |   |   |  |
| 24. FUNERAL DIRECTOR<br><b>W. Morris Pope</b>  |   | ADDRESS<br><b>Wheaton, Mo.</b>  |  | 25. DATE RECD. BY LOCAL REG.<br><b>1-25-60</b>  | 26. REGISTRAR'S SIGNATURE<br><b>Grace Williams</b>   |   |   |  |

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

JUL 12 1960

JUN 13 1960

**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 James Kenneth Durr  
Licensed Embalmer No. 4767  
P. O. Address Wheaton

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.