

# RI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

60-000259

FILED VS FEB 1 1960 042

Registration District No. Primary Registration District No. 1000 Registrar's No. 102

STATE FILE NUMBER

1. PLACE OF DEATH a. COUNTY <b>Buchanan</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Missouri</b> b. COUNTY <b>Nodaway</b>			
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>Saint Joseph</b>		Length of stay in 1b <b>1 day</b>		c. CITY OR TOWN <b>Skidmore</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>Sister's Hospital</b>			Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location)		Reside on Farm Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Middle Last <b>William Allen</b>				4. DATE OF DEATH Month Day Year <b>Jan. 23 1960</b>			
5. SEX <b>male</b>	6. COLOR OR RACE <b>cau</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>3-18-1884</b>	9. AGE (last birthday) <b>75</b>	IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HR
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>Mt. Moriah, Mo.</b>		12. CITIZEN OF WHAT COUNTRY <b>USA</b>	
13a. FATHER'S NAME <b>John Allen</b>		13b. MOTHER'S MAIDEN NAME <b>Sabetha McDonald</b>		14. NAME OF HUSBAND OR WIFE <b>Mrs. Jessie Allen</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, np, or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>unknown</b>		17. INFORMANT Address <b>Mrs. Jessie Allen Skidmore, 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>Thrombosis of lenticulostriate branch of right middle cerebral artery</b> <b>1 day</b> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. ) DUE TO (b) <b>Cerebral atherosclerosis</b> <b>years</b> DUE TO (c) <b>Generalized arteriosclerosis</b> <b>years</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <b>Arteriosclerotic heart disease.</b>							INTERVAL BETWEEN ONSET AND DEATH
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 Month, Day, Year a.m. p.m.							
20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" 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>1/22/60</b> to <b>1/23/60</b> and last saw her alive on <b>1/23/60</b> Death occurred at <b>7:45</b> p.m. on the date stated above, and to the best of my knowledge, from the causes stated.							
22a. SIGNATURE <i>Cary H. Potter, Jr. M.D.</i>		22b. ADDRESS <b>Phy. &amp; Surg. Bldg. - St. Joseph, Mo.</b>		22c. DATE SIGNED <b>1/25/60</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE <b>1-27-1960</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Graham Cemetery</b>		23d. LOCATION (City, town, or county) (State) <b>Graham, Missouri</b>		
24. FUNERAL DIRECTOR <i>M. J. Stinson</i>		ADDRESS <i>Maryville</i>		25. DATE RECD. BY LOCAL REG. <b>Jan. 28, 1960</b>		26. REGISTRAR'S SIGNATURE <i>Mrs. Clark Goodell</i>	

(License of Registrar's Statement on Reverse Side)

DOCUMENT

BY AFFIDAVIT OF C. A. Potter, Jr., Medical Certification

**STATEMENT BY LICENSED EMBALMER**

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed  
or by \_\_\_\_\_, Student Embalmer No. \_\_\_\_\_  
working under my personal supervision.

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

Signed

*[Handwritten Signature]*

Licensed Embalmer No. 22

P. O. Address Maryland

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to  
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.