

RI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-60-000380

FILED VS JAN 11 1960 042

Registration District No. _____ Primary Registration District No. 1000 Registrar's No. 9 STATE FILE NUMBER _____

DED

1. PLACE OF DEATH a. COUNTY Buchanan				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY Buchanan					
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN St. Joseph		Length of stay in lb 40 years		c. CITY OR TOWN St. Joseph		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>			
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR Hillside Nursing Home INSTITUTION 718 No. 7th St.			Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location) 1523 No. 2nd St.		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First MIDDLE Last DELLA OXLEY PRICE				4. DATE OF DEATH Month Day Year January 3 1960					
5. SEX Female	6. COLOR OR RACE White	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>		8. DATE OF BIRTH 9/20/1876	9. AGE (last birthday) 83	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) At Home			10b. KIND OF BUSINESS OR INDUSTRY Home		11. BIRTHPLACE (City and state or country) Macon Missouri		12. CITIZEN OF WHAT COUNTRY USA		
13a. FATHER'S NAME Robert F. Oxley			13b. MOTHER'S MAIDEN NAME Melcina Jane Butler			14. NAME OF HUSBAND OR WIFE Deceased			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No			16. SOCIAL SECURITY NO. None		17. INFORMANT Mrs. Lawrence Hepple Columbia, Mo. Address				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Pulmonary edema</i>								INTERVAL BETWEEN ONSET AND DEATH 1 mo	
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <i>Coronary insufficiency</i>								?	
DUE TO (c) <i>Arteriosclerosis</i>								?	
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 <i>Jan 20 1959</i> to <i>Dec 31 59</i> and last saw her ^{her} alive on <i>Dec 31 59</i> Death occurred at <i>10:10 A</i> m on the date stated above, and to the best of my knowledge, from the causes stated.									
22a. SIGNATURE (Degree or title) <i>J.L. Mothershead Mrs</i>				22b. ADDRESS <i>2608 Fredrick</i>			22c. DATE SIGNED <i>1-5-60</i>		
23a. BURIAL, CREMATION, REMOVAL (Specify) Removal		23b. DATE 1/5/1960	23c. NAME OF CEMETERY OR CREMATORY Highridge Cemetery		23d. LOCATION (City, town, or county) (State) Stanberry Missouri				
24. FUNERAL DIRECTOR <i>Stoney Funeral Home</i>			ADDRESS St. Joseph, Mo.		25. DATE RECD. BY LOCAL REG. <i>Jan. 7, 1960</i>		26. REGISTRAR'S SIGNATURE <i>Mrs. Clark Goodell</i>		

DOCUMENT

J.L. Mothershead, M.D. - SIGNIFICATION

BY AFFIDAVIT OF

APR 7 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

Charles E. Bennett

Licensed Embalmer No. 4677

P. O. Address St Joseph M

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