

**DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH**

**-60-000517**

ED VS FEB 3 1960 47

Registration District No. 47 Primary Registration District No. 3008 Registrar's No. 18

STATE FILE NUMBER

1. PLACE OF DEATH a. COUNTY <b>Callaway</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Missouri</b> b. COUNTY <b>Pettis</b>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>Fulton</b>		Length of stay in 1b <b>2mos. 25das.</b>	c. CITY OR TOWN <b>Sedalia</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 <b>State Hospital No. 1</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <b>422 West 5th Street</b> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <b>LYLA</b> Middle <b>HEWITT</b> Last			4. DATE OF DEATH Month <b>January</b> Day <b>25</b> Year <b>1960</b>
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input checked="" type="checkbox"/>	8. DATE OF BIRTH <b>6-11-1888</b>
9. AGE (last birthday) <b>71</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>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Home</b>	11. BIRTHPLACE (City and state or country) <b>LaMonte, Missouri</b>
12. CITIZEN OF WHAT COUNTRY <b>U.S.A.</b>		13a. FATHER'S NAME <b>Arthur ??</b>	
13b. MOTHER'S MAIDEN NAME <b>Alta ??</b>		14. NAME OF HUSBAND OR WIFE <b>Unknown</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>Unknown</b>	17. INFORMANT <b>State Hospital No. 1, Fulton, Mo.</b> 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) <b>Acute bronchitis and bronchiolitis</b>			INTERVAL BETWEEN ONSET AND DEATH
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <b>Chronic brain syndrome</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>Decubitus ulcers</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
19. WAS AUTOPSY PERFORMED? YES <input checked="" 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 Hour Month, Day, Year a.m. p.m.			
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. <input checked="" type="checkbox"/> attended the deceased from <b>St. Hosp. 10-30-1959</b> to <b>1-25-1960</b> and last saw him alive on <b>XXXXXXXX</b>		Death occurred at <b>5:15 a.m.</b> m on the date stated above, and to the best of my knowledge, from the causes stated.	
22a. SIGNATURE <i>James K. Altman M.D.</i> (Degree or title)		22b. ADDRESS <b>State Hospital No. 1</b>	22c. DATE SIGNED <b>1-25-60</b>
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>	23b. DATE <b>1-27-60</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Surprise Cemetery</b>	23d. LOCATION (City, town, or county) (State) <b>Warrensberg, Missouri</b>
24. FUNERAL DIRECTOR <b>McLaughlin Bros.</b>	ADDRESS <b>Sedalia, Mo</b>	25. DATE RECD. BY LOCAL REG. <b>January-25-1960</b>	26. REGISTRAR'S SIGNATURE <i>Maretha Lawrence</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  
or by \_\_\_\_\_ Student Embalmer No. \_\_\_\_\_  
working under my personal supervision.

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

Signed H. P. McCreary

Licensed Embalmer No. 3153

P.O. Address Sedalia;

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.