

**DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH**  
**FILED VS JAN 26 1960**

-60-000535  
 -60-000535  
 STATE FILE NUMBER

Registration District No. 47 Primary Registration District No. 3008 Registrar's No. 13

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> COUNTY <b>Pettis</b>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>Fulton</b>		Length of stay in 1b <b>1mo. 12das.</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>413 East 7th Street</b> Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>

3. NAME OF DECEASED (Type or print) <b>JOSEPH R. RETHERFORD</b>			4. DATE OF DEATH <b>January 20, 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>4-14-1892</b>	9. AGE (last birthday) <b>67</b>	IF UNDER 1 YEAR Months Days 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>Farming</b>	11. BIRTHPLACE (City and state or country) <b>Missouri</b>	12. CITIZEN OF WHAT COUNTRY <b>U.S.A.</b>	
13a. FATHER'S NAME <b>Laben Retherford</b>		13b. MOTHER'S MAIDEN NAME <b>Alice Henderson</b>	14. NAME OF HUSBAND OR WIFE <b>Annie Retherford</b>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>Unknown</b>		16. SOCIAL SECURITY NO. <b>Unknown</b>	17. INFORMANT Address <b>State Hospital No. 1, Fulton, 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>Cerebral Thrombosis</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>Cerebral Arteriosclerosis</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 <b>7:40 a.m.</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.) <b>St. Hospital</b>		20f. CITY, TOWN, OR LOCATION COUNTY STATE <b>12-8-1959</b> to <b>1-20-1960</b> and last saw him <b>XXXXXXXX</b>	
21. Attended the deceased from <b>7:40 a.m.</b> on the date stated above, and to the best of my knowledge, from the causes stated.			

22a. SIGNATURE (Degree or title) <b>William J. Favicelle MD</b>		22b. ADDRESS <b>State Hospital No. 1</b>		22c. DATE SIGNED <b>1-20-60</b>
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Removal</b>	23b. DATE <b>Jan 20-1960</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Pilot Grove</b>	23d. LOCATION (City, town, or county) (State) <b>Mo</b>	
24. FUNERAL DIRECTOR <b>Wallace Funeral Home Fulton Mo</b>		25. DATE RECD. BY LOCAL REG. <b>Jan. 20 - 1960</b>	26. REGISTRAR'S SIGNATURE <b>Martha Lawrence</b>	

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 A. R. Moore

NAME OF DECEASED

DATE OF DEATH

Licensed Embalmer No. 199

P. O. Address Fulton,

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.