

RI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-60-000725

FILED VS FEB 10 1960

Registration District No. 73 Primary Registration District No. 5291 Registrar's No. 12 STATE FILE NUMBER

DED

1. PLACE OF DEATH a. COUNTY Clay		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY Clay	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Liberty		Length of stay in 1b 4 yrs.	c. CITY OR TOWN Liberty Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Odds Fellows Hospital		Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	d. STREET ADDRESS (If outside, give location) Odd Fellow Hospital Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <i>Sarah</i> Middle CLARK Last <i>Feniter</i>			4. DATE OF DEATH Month February Day 1 Year 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 3-22-1878
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Domestic	9. AGE (last birthday) 81 IF UNDER 1 YEAR Months Days IF UNDER 24 HR Hours Min.
11. BIRTHPLACE (City and state or country) Carthage, Missouri		12. CITIZEN OF WHAT COUNTRY U.S.A.	
13a. FATHER'S NAME John Babcock		13b. MOTHER'S MAIDEN NAME Adeline Gooding	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 no		16. SOCIAL SECURITY NO. None	17. INFORMANT Joseph D. Clark, 605 So. Cedar, Indep., 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) <u><i>Atherosclerosis</i></u>		INTERVAL BETWEEN ONSET AND DEATH
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (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) <u><i>Rheumatoid Arthritis several years</i></u>		PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> <input checked="" type="checkbox"/>
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 <u><i>4-12-56</i></u> to <u><i>2-1-60</i></u> and last saw her <u><i>alive</i></u> on <u><i>1-31-60</i></u> Death occurred at <u><i>9:50 A</i></u> on the date stated above, and to the best of my knowledge, from the causes stated.		
22a. SIGNATURE (Degree or title) <u><i>Clouff Goodson</i></u>		22b. ADDRESS <u><i>Liberty, Mo.</i></u>
22c. DATE SIGNED <u><i>2/1/60</i></u>		
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE 2-4-60	23c. NAME OF CEMETERY OR CREMATORY Mount Moriah Cemetery
23d. LOCATION (City, town, or county) Kansas City, Mo.		
24. FUNERAL DIRECTOR Geo. C. Carson & Sons, Independence, Mo.		25. DATE RECD. BY LOCAL REG. 2-5-60
26. REGISTRAR'S SIGNATURE <u><i>Mabel Brecken</i></u>		

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 by _____ or by _____, Student Embalmer No. _____

working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed *R. Kenneth Patterson*

Licensed Embalmer No. 4697

P. O. Address Indy, Ind.

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.