

REGISTRATION DISTRICT NO. 2 Primary Registration District No. 307 Registrar's No. 9

RI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-60-000824

FILED VS. JAN 25 1960 82

STATE FILE NUMBER

1. PLACE OF DEATH a. COUNTY <b>COOPER</b>				2. USUAL RESIDENCE (Where deceased lived if institution: Residence before admission) a. STATE <b>Mo</b> b. COUNTY <b>JACKSON</b>			
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>BLACKWATER TWP</b>		Length of stay in 1b <b>1 hr</b>		c. CITY OR TOWN <b>K.C. Mo</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>14 MILES W. BOONVILLE</b>				Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>		d. STREET ADDRESS (If outside, give location) <b>11 W. 66th</b>	
3. NAME OF DECEASED (Type or print) First <b>JO</b> Middle <b>ANN</b> Last <b>CURTIS</b>				4. DATE OF DEATH Month <b>JAN.</b> Day <b>17,</b> Year <b>1960</b>			
5. SEX <b>FEMALE</b>		6. COLOR OR RACE <b>W</b>		7. Married <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>		8. DATE OF BIRTH <b>10/7/50</b>	
9. AGE (last birthday) <b>9</b>		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) <b>STUDENT</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>SCHOOL</b>		11. BIRTHPLACE (City and state or country) <b>COLUMBIA MO</b>	
12. CITIZEN OF WHAT COUNTRY <b>USA</b>							
13a. FATHER'S NAME <b>WALTER CURTIS II</b>				13b. MOTHER'S MAIDEN NAME <b>ANN HINSHAW</b>		14. NAME OF HUSBAND OR WIFE <b>_____</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>NONE</b>		17. INFORMANT <b>HAROLD HINSHAW - Columbia 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>Brain injury - shock</b>						INTERVAL BETWEEN ONSET AND DEATH <b>2 hrs</b>	
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <b>Violence</b>							
DUE TO (c) <b>Auto wreck</b>							
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 checked="" type="checkbox"/> No <input type="checkbox"/> Unknown	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20a. ACCIDENT <input checked="" 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.) <b>Violent blow caused by Auto Wreck</b>			
20c. TIME OF INJURY Hour <b>about 3:30</b> p.m. Month, Day, Year <b>1 17 60</b>							
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.) <b>Highway 40 - 12 miles west Booneville Coop Mo</b>		20f. CITY, TOWN, OR LOCATION <b>COOP</b>		COUNTY <b>Mo</b> STATE <b>Mo</b>	
21. I attended the deceased from <b>no attendance</b> and last saw her/him alive on _____ Death occurred at <b>about 3:30 P</b> m on the date stated above, and to the best of my knowledge, from the causes stated.							
22a. SIGNATURE (Degree or title) <b>Dr. Decker MD - Carver Booneville Coop Mo</b>				22b. ADDRESS <b>Booneville Coop Mo</b>		22c. DATE SIGNED <b>1/17/60</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		23b. DATE <b>1-19-60</b>		23c. NAME OF CEMETERY OR CREMATORY <b>MEMORIAL PARK</b>		23d. LOCATION (City, town, or county) <b>COLUMBIA Mo</b>	
24. FUNERAL DIRECTOR <b>PARKER SERVICE Columbia Mo</b>				25. DATE RECD. BY LOCAL REG. <b>1-18-60</b>		26. REGISTRAR'S SIGNATURE <b>[Signature]</b>	

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

APR 19 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 J. W. Phillips

Licensed Embalmer No. 4897

P. O. Address Chumb...

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