

FEDERAL DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

FILED VS FEB 15 1960

=60-000857

Registration District No. 096 Primary Registration District No. \_\_\_\_\_ Registrar's No. 11 STATE FILE NUMBER

1. PLACE OF DEATH a. COUNTY <u>Dallas</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Dallas</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Washington Jwp. Leake</u>		c. CITY OR TOWN <u>Long Lane</u> Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>Long Lane A.F.P.</u>		d. STREET ADDRESS (If outside, give location) <u>A.F.P.</u> Reside on Farm Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	

3. NAME OF DECEASED (Type or print) First <u>LEORA</u> Middle <u>B.</u> Last <u>COLISHAW</u>			4. DATE OF DEATH Month <u>FEB.</u> Day <u>5</u> Year <u>1960</u>		
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5. SEX <u>Female</u>	6. COLOR OR RACE <u>white</u>	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <u>Oct. 19, 1898</u>	9. AGE (last birthday) <u>78</u>	IF UNDER 1 YEAR Months _____ Days _____	IF UNDER 24 HR Hours _____ Min. _____
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>	10b. KIND OF BUSINESS OR INDUSTRY _____	11. BIRTHPLACE (City and state or country) <u>Indiana</u>	12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>
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13a. FATHER'S NAME <u>Thomas Richardson</u>	13b. MOTHER'S MAIDEN NAME <u>Katherine Gaillions</u>	14. NAME OF HUSBAND OR WIFE _____
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>no</u>	16. SOCIAL SECURITY NO. _____	17. INFORMANT <u>Mrs. Mrs. Dill Long Lane mo.</u> Address _____
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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>Congestive Heart Failure</u>		INTERVAL BETWEEN ONSET AND DEATH <u>6 mo</u>
DUE TO (b) <u>Auricular Fibrillation</u>		
DUE TO (c) <u>Chr. Myocarditis</u>		

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>Arteriosclerosis</u>	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
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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.) _____
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20c. TIME OF INJURY Hour _____ a.m. _____ p.m. _____ Month, Day, Year _____
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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 _____
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21. I attended the deceased from <u>1940</u> to <u>Feb. 5, 60</u> and last saw her <u>live</u> on <u>Feb. 1, 1960</u> Death occurred at <u>5:30</u> on the date stated above, and to the best of my knowledge, from the causes stated.
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21a. SIGNATURE (Degree or title) <u>C.O. Hammon M.D.</u>	21b. ADDRESS <u>Buffalo, Mo</u>	21c. DATE SIGNED <u>2-9-60</u>
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23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Buried Feb. 7, 1960</u>	23b. DATE _____	23c. NAME OF CEMETERY OR CREMATORY <u>Center Point</u>	23d. LOCATION (City, town, or county) (State) <u>Dallas Co. mo.</u>
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24. FUNERAL DIRECTOR <u>L.B. Jones</u> ADDRESS <u>Buffalo, mo.</u>	25. DATE RECD. BY LOCAL REG. <u>2/10/60</u>	26. REGISTRAR'S SIGNATURE <u>Mrs Vera Petree</u>
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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 me, Student Embalmer No. ✓

working under my personal supervision.

Student ✓  
Signature of Student Embalmer

Signed R.E. Cheatham

Licensed Embalmer No. 3813

P. O. Address Buffalo, N.Y.

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.