

R. DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

FILED VS JAN 26 1960

=60-000882

Registration District No. 100 Primary Registration District No. _____ Registrar's No. 4

STATE FILE NUMBER

1. PLACE OF DEATH a. COUNTY Dent		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY Dent	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Springcreek		c. CITY OR TOWN Salem Mo. R^k 2	
Length of stay in lb 40Trs		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION At home		d. STREET ADDRESS (If outside, give location) 3 mi. North on Hiway 72	
Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>		Reside on Farm Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Harvey Middle S. Last Flett		4. DATE OF DEATH Month January Day 19 Year 1960	
5. SEX Male	6. COLOR OR RACE White	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH 9-17-84
9. AGE (last birthday) 75		IF UNDER 1 YEAR IF UNDER 24 HR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer		10b. KIND OF BUSINESS OR INDUSTRY Farming	
11. BIRTHPLACE (City and state or country) Dent County Mo.		12. CITIZEN OF WHAT COUNTRY U.S. A.	
13a. FATHER'S NAME Alexander Flett		13b. MOTHER'S MAIDEN NAME Sarah J. Frost	
14. NAME OF HUSBAND OR WIFE Sadie Flett			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No. None		16. SOCIAL SECURITY NO. 495-40-9636	
17. INFORMANT Sadie J. Flett		Address Salem Mo. R²	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) BRONCHIAL PNEUMONIA			INTERVAL BETWEEN ONSET AND DEATH 10 DAYS
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) PARKINSON'S DISEASE			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 Hour _____ a.m. _____ p.m. Month, Day, Year _____			
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.) 8/7/56	20f. CITY, TOWN, OR LOCATION 1/18/60	COUNTY _____ STATE _____
21. I attended the deceased from 8/7/56 to 1/18/60 and last saw her/him alive on 1/18/60 Death occurred at 8 A on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE R. Hunt (Degree or title) M.D.		22b. ADDRESS SALEM MO. MO	22c. DATE SIGNED 1/21/60
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE 1-21-60	23c. NAME OF CEMETERY OR CREMATORY Ceadgrove	23d. LOCATION (City, town, or county) Salem Mo.
24. FUNERAL DIRECTOR Carl K. Spencer Salem Mo.		25. DATE RECD. BY LOCAL REG. 1/21/60	26. REGISTRAR'S SIGNATURE M.M. Stark, M.D.

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF:

APR 4 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

Carl H. Spinner

Licensed Embalmer No. 9370

P. O. Address Valer

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.