

RI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

FILED VS JAN 26 1960

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STATE FILE NUMBER

DED

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

1. PLACE OF DEATH a. COUNTY Franklin				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY Franklin					
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Central		Length of stay in 1b		c. CITY OR TOWN Rural Central Twp.		Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>			
c. FULL NAME OF (if NOT in hospital, give location) HOSPITAL OR INSTITUTION Route 2			Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (if outside, give location) Wallsford Road		Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First Emma Middle Lou Last McNees				4. DATE OF DEATH January 23, 1960 Month January Day 23 Year 1960					
5. SEX Female	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 3/15/79		9. AGE (last birthday) 80	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)			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (City and state or country) Mt. Home, N. Carolina		12. CITIZEN OF WHAT COUNTRY USA		
13a. FATHER'S NAME Joseph Dunlop			13b. MOTHER'S MAIDEN NAME Fanny Reed		14. NAME OF HUSBAND OR WIFE John McNees				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. (If yes, give war or dates of service)		17. INFORMANT John McNees		Address St. Clair, Mo.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Septicemia fulminans - acute DUE TO (b) long standing arteriosclerotic CVD disease DUE TO (c) _____ Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.								INTERVAL BETWEEN ONSET AND DEATH 24 hr 2 yrs	
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 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 _____		Had been hospitalized for long periods over last 3-6 mos							
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.)		20f. CITY, TOWN, OR LOCATION		COUNTY		STATE	
21. I attended the deceased from June 1959 to Death and last saw her alive on 1-21-60 Death occurred at 4:30 A. m on the date stated above, and to the best of my knowledge, from the causes stated.									
22a. SIGNATURE John Paul Now (Degree or title)				22b. ADDRESS St. Clair, Mo.			22c. DATE SIGNED 1-23-60		
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 1/25/60	23c. NAME OF CEMETERY OR CREMATOR Midlawn Memorial Gardens		23d. LOCATION (City, town, or county) Union, Mo.		23e. DATE RECD. BY LOCAL REG. Jan 23-60		23f. REGISTRAR'S SIGNATURE Shirley Smith
24. FUNERAL DIRECTOR Casey Lenox			ADDRESS St. Clair, Mo.						

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

JAN 23 1980

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

H. M. Lerrot

Licensed Embalmer No. *3601*

P. O. Address *St. Clair, La*

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.