

RI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

=60-001054

FILED VS JAN 25 1960/28

STATE FILE NUMBER

Registration District No. _____ Primary Registration District No. 2000 Registrar's No. 55 C

1. PLACE OF DEATH a. COUNTY <u>Green</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Mo</u> b. COUNTY <u>Polk</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Springfield</u>	Length of stay in 1b <u>Two Years</u>	c. CITY OR TOWN <u>Morrisville</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>Foster Nursing Home</u>		d. STREET ADDRESS (If outside, give location) <u>None</u>	Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>

3. NAME OF DECEASED (Type or print) First <u>Marion</u> Middle <u>Jackson</u> Last <u>Euliss</u>			4. DATE OF DEATH Month <u>JAN-</u> Day <u>12</u> Year <u>1960</u>		
5. SEX <u>Male</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>3/26/1873</u>	9. AGE (last birthday) <u>86</u>	IF UNDER 1 YEAR Months _____ Days _____
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>	11. BIRTHPLACE (City and state or country) <u>Morrisville, Mo</u>	12. CITIZEN OF WHAT COUNTRY <u>USA</u>	
13a. FATHER'S NAME <u>Henry Euliss</u>		13b. MOTHER'S MAIDEN NAME <u>Jane Shoffner</u>		14. NAME OF HUSBAND OR WIFE <u>None</u>	
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 Address <u>Foster Nursing Home, Springfield, Mo</u>		

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (b) <u>G.I. tract malignancy & metastases</u>		INTERVAL BETWEEN ONSET AND DEATH <u>over 6 mo</u>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) _____ DUE TO (a) <u>Bronchopneumonia</u>	<u>1 week</u>	
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 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.)
20f. CITY, TOWN, OR LOCATION		COUNTY	STATE

21. I attended the deceased from Oct '59 to Jan '60 and last saw ^{her}him alive on Jan 8, 1960
Death occurred at 7:30 A.M. on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE <u>Harris E. Crabb, M.D.</u> (Degree or title)	22b. ADDRESS <u>1630 N. Jefferson Springfield Mo.</u>	22c. DATE SIGNED <u>1/15/60</u>
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23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE <u>Jan. 14, 1960</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Hickory Grove Cemetery</u>	23d. LOCATION (City, town, or county) (State) <u>Southeast - Morrisville, Mo.</u>
24. FUNERAL DIRECTOR <u>Paul D. Butler</u> <u>Bolivar, Mo.</u>		25. DATE RECD. BY LOCAL REG. <u>1-18-60</u>	26. REGISTRAR'S SIGNATURE <u>Effie S. Meeten</u>

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

