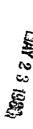
	VISION OF HEALTH - STANDARD CERTIFICATE OF DEATH D VS FEB 1 5 1960 1 2 7 = 7	
DED	Registration District NoPrimary Registration District No. 3625 Registrar's No. 34 STATE FILE NUMBER	
	1. PLACE OF DEATH a. COUNTY B. CITY (If outside corporate limits, give TOWNSHIP only) TOWN C. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION C. FULL NAME OF (IF NOT in hospital, give location) HOSPITAL OR INSTITUTION C. FULL NAME OF (IF NOT in hospital, give location) HOSPITAL OR INSTITUTION C. FULL NAME OF (IF NOT in hospital, give location) HOSPITAL OR INSTITUTION C. FULL NAME OF (IF NOT in hospital, give location) HOSPITAL OR INSTITUTION C. FULL NAME OF (IF NOT in hospital, give location) HOSPITAL OR INSTITUTION C. FULL NAME OF (IF NOT in hospital, give location) HOSPITAL OR INSTITUTION C. FULL NAME OF (IF NOT in hospital, give location) HOSPITAL OR INSTITUTION C. FULL NAME OF (IF NOT in hospital, give location) HOSPITAL OR INSTITUTION C. FULL NAME OF (IF NOT in hospital, give location) HOSPITAL OR INSTITUTION C. FULL NAME OF (IF NOT in hospital, give location) HOSPITAL OR INSTITUTION C. FULL NAME OF (IF NOT in hospital, give location) HOSPITAL OR INSTITUTION C. FULL NAME OF (IF NOT in hospital, give location) HOSPITAL OR INSTITUTION C. FULL NAME OF (IF NOT in hospital, give location) HOSPITAL OR INSTITUTION C. FULL NAME OF (IF NOT in hospital, give location) HOSPITAL OR INSTITUTION C. FULL NAME OF (IF NOT in hospital, give location) HOSPITAL OR INSTITUTION C. FULL NAME OF (IF NOT in hospital, give location) HOSPITAL OR INSTITUTION C. FULL NAME OF (IF NOT in hospital, give location) HOSPITAL OR INSTITUTION C. FULL NAME OF (IF NOT in hospital, give location) HOSPITAL OR INSTITUTION C. FULL NAME OF (IF NOT in hospital, give location) HOSPITAL OR INSTITUTION C. FULL NAME OF (IF NOT in hospital, give location) HOSPITAL OR INSTITUTION C. FULL NAME OF (IF NOT in hospital, give location) HOSPITAL OR INSTITUTION C. FULL NAME OF (IF NOT in hospital, give location) HOSPITAL OR INSTITUTION C. FULL NAME OF (IF NOT in hospital, give location)	
DOCUMENT	3. NAME OF DECEASED First Middle Lest 4. DATE OF DEATH DEATH	
	above cause (a), stating the underlying cause last. DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) PART III. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal there a pregnancy in last 90 days. The condition given in PART I (a) PART III. If deceased was female was there a pregnancy in last 90 days. The condition given in PART I (a) PART III. If deceased was female was there a pregnancy in last 90 days. The condition given in PART II of item 18.) PERFORMED? PERFORMED. PERFORME	
AFFIDAVIT OF	20d. INJURY OCCURRED WHILE AT WORK 20e. PLACE OF INJURY (e.g., in or about home, hort while AT WORK 20f. CITY, TOWN, OR LOCATION 20f. COUNTY 20f. COUNTY 20f. CITY, TOWN, OR LOCATION 20f. CITY, TOWN, OR LOCATION	
BY A	24. FUNERAL DIRECTOR ADDRESS 25. DATE RECD. BY LOCAL REG. 26. REGISTRAR'S SIGNATURE F. L. Schaberg 2/45 2 78 SF July 1960 Millard Bigume (Licensed Embalmer's Statement on Reverse Side)	



STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is	s recorded on the reverse side of this certificate was embalmed by
or by	, Student Embalmer No
working under my personal supervision.	Signed To Shakera
StudentSignature of Student Embalmer	_ Signed / Service / Servi
	Licensed Embalmer No. 45/

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