

# DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

=60-001285  
STATE FILE NUMBER

FILED VS FEB 9 1960 138

Registration District No. \_\_\_\_\_ Primary Registration District No. 4220 Registrar's No. 3

<b>1. PLACE OF DEATH</b> a. COUNTY <u>Hickory</u> b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Wheatland</u> Length of stay in 1b <u>9 Mo.</u> c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>Central Wheatland</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		<b>2. USUAL RESIDENCE</b> (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> , b. COUNTY <u>Hickory</u> c. CITY OR TOWN <u>Wheatland</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> d. STREET ADDRESS (If outside, give location) <u>Central Wheatland</u> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
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<b>3. NAME OF DECEASED</b> (Type or print) First <u>Charles</u> Middle <u>A.</u> Last <u>Gist</u>			<b>4. DATE OF DEATH</b> Month <u>Jan</u> Day <u>29</u> Year <u>1960</u>			
<b>5. SEX</b> <u>Male</u>	<b>6. COLOR OR RACE</b> <u>White</u>	<b>7. Married</b> <input type="checkbox"/> <b>Never Married</b> <input type="checkbox"/> <b>Widowed</b> <input checked="" type="checkbox"/> <b>Divorced</b> <input type="checkbox"/>	<b>8. DATE OF BIRTH</b> <u>Feb 24-82</u>	<b>9. AGE</b> (last birthday) <u>77</u>	IF UNDER 1 YEAR Months <u>11</u> Days <u>3</u> Hours <u></u> Min. <u></u>	
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>General Merchandise</u>		<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <u>Grocery/Clothing</u>		<b>11. BIRTHPLACE</b> (City and state or country) <u>Cass Co. Ind.</u>		
<b>12. CITIZEN OF WHAT COUNTRY</b> <u>U.S.A.</u>		<b>13a. FATHER'S NAME</b> <u>Burgess Gist</u>		<b>13b. MOTHER'S MAIDEN NAME</b> <u>Anna Maria Tracy</u>		
<b>14. NAME OF HUSBAND OR WIFE</b> <u>Eva Pearl Gist</u>		<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>				
<b>16. SOCIAL SECURITY NO.</b> <u>None</u>		<b>17. INFORMANT</b> <u>Chas Gist - Wheatland, Mo</u> Address <u></u>				

<b>18. CAUSE OF DEATH</b> (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Bronchial Pneumonia</u> DUE TO (b) <u>asthmaty</u> DUE TO (c) <u></u> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.		INTERVAL BETWEEN ONSET AND DEATH <u>2 Weeks</u>
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PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>Cancer of thoracic spine</u>		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		
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<b>19. WAS AUTOPSY PERFORMED?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	<b>20a. ACCIDENT</b> <input type="checkbox"/> <b>SUICIDE</b> <input type="checkbox"/> <b>HOMICIDE</b> <input type="checkbox"/>	<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in PART I or PART II of item 18.)		
<b>20c. TIME OF INJURY</b> Hour <u></u> a.m. <u></u> p.m. <u></u> Month, Day, Year <u></u>		<b>20d. INJURY OCCURRED WHILE AT WORK</b> <input type="checkbox"/> <b>NOT WHILE AT WORK</b> <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** March 1947 to Jan 27, 1960 and last saw <sup>her</sup> him alive on Jan 26, 1960

Death occurred at 6:40 p.m. on the date stated above, and to the best of my knowledge, from the causes stated.

<b>22a. SIGNATURE</b> (Degree or title) <u>J.E. Briggs, D.O.</u>	<b>22b. ADDRESS</b> <u>Wheatland, Mo</u>	<b>22c. DATE SIGNED</b> <u>2-2-60</u>
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<b>23a. BURIAL, CREMATION, REMOVAL</b> (Specify) <u>Burial</u>	<b>23b. DATE</b> <u>Feb 1-1960</u>	<b>23c. NAME OF CEMETERY OR CREMATORY</b> <u>Gardner Cemetery</u>	<b>23d. LOCATION</b> (City, town, or county) (State) <u>Wheatland, Mo</u>
<b>24. FUNERAL DIRECTOR</b> ADDRESS <u>Silbert Hathaway - Wheatland, Mo</u>		<b>25. DATE RECD. BY LOCAL REG.</b> <u>Feb 2-1960</u>	
<b>26. REGISTRAR'S SIGNATURE</b> <u>Mary Johnson</u>			

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

DEPT. OF HEALTH

**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 Chas. Gilbert Hathaway

Licensed Embalmer No. 4267

P. O. Address W. Hathaway

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.