

REGISTRATION DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

=60-001288

FILED VS FEB 15 1960

STATE FILE NUMBER

Registration District No. 139 Primary Registration District No. \_\_\_\_\_ Registrar's No. 5

1. PLACE OF DEATH a. COUNTY <u>HOLT</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MISSOURI</u> b. COUNTY <u>HOLT</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>MOUND CITY</u>	Length of stay in 1b <u>10 YEARS</u>	c. CITY OR TOWN <u>MOUND CITY</u>	Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION		d. STREET ADDRESS (If outside, give location)	Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print) First <u>CORA</u> Middle <u>BELLE</u> Last <u>LOUDEN</u>			4. DATE OF DEATH Month <u>FEB.</u> Day <u>8</u> Year <u>1960</u>			
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <u>10/19/1880</u>	9. AGE (last birthday) <u>79</u>	IF UNDER 1 YEAR Months _____ Days _____	IF UNDER 24 HR Hours _____ Min. _____

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>IN THE HOME</u>		11. BIRTHPLACE (City and state or country) <u>GREENE Co. IOWA</u>		12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>	
13a. FATHER'S NAME <u>ELIHU W. BROCK</u>			13b. MOTHER'S MAIDEN NAME <u>HATTIE J. CLOPTON</u>		14. NAME OF HUSBAND OR WIFE <u>TAYLOR J. LOUDEN</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. <u>UNKNOWN</u>		17. INFORMANT <u>MRS. Kelson FLEENER, Mound City, Mo</u>		Address	
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18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY:			INTERVAL BETWEEN ONSET AND DEATH		
IMMEDIATE CAUSE (a) <u>Coronary Occlusion</u>					
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)				PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input checked="" 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.)	
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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 2-5-60 to 2-8-60 and last saw her alive on 2-8-60  
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 <u>D.P. Perry M.D.</u>	(Degree or title)	22b. ADDRESS <u>Mound City Mo</u>	22c. DATE SIGNED <u>2-10-60</u>
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23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	23b. DATE <u>2/11/1960</u>	23c. NAME OF CEMETERY OR CREMATORY <u>OREGON CEMETERY</u>	23d. LOCATION (City, town, or county) (State) <u>OREGON, MISSOURI</u>
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24. FUNERAL DIRECTOR <u>Garnett Crawford</u>	ADDRESS <u>Mound City, Mo</u>	25. DATE RECD. BY LOCAL REG. <u>2/10/1960</u>	26. REGISTRAR'S SIGNATURE <u>Garnett Crawford</u>
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(Licensed Embalmer's Statement on Reverse Side)

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

MAR 1 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 James Crawford

Licensed Embalmer No. 4796

P. O. Address Mound City

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.