

FRI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

=60-002424

FILED VS JAN 11 1960

Registration District No. 184 Primary Registration District No. 3038 Registrar's No. 1

STATE FILE NUMBER

NDED

1. PLACE OF DEATH a. COUNTY <u>LINN</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Mo.</u> b. COUNTY <u>LINN</u>				
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>BROOKFIELD</u>		Length of stay in 1b		c. CITY OR TOWN <u>BROOKFIELD</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 <u>CRAMER Rest Home</u>			Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location) <u>620 N. MONROE</u>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>MARY MARGARET O'SHAUGHNESSY</u>				4. DATE OF DEATH Month Day Year <u>JAN 3 1960</u>				
5. SEX <u>FEMALE</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>4-14-1922</u>	9. AGE (last birthday) <u>37</u>	IF UNDER 1 YEAR Months Days Hours Min.	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>Home</u>		11. BIRTHPLACE (City and state or country) <u>MARCELINE Mo.</u>		12. CITIZEN OF WHAT COUNTRY <u>USA</u>		
13a. FATHER'S NAME <u>CALEB OTHIC</u>			13b. MOTHER'S MAIDEN NAME <u>MARY ANN McDaniel</u>		14. NAME OF HUSBAND OR WIFE <u>WM. O'SHAUGHNESSY</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>NO</u>		17. INFORMANT Address <u>HANNAH BARTON BROOKFIELD 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 (a) <u>Arteriosclerosis, generalized</u> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. 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) <u>fractured hip</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								
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20a. ACCIDENT <input checked="" 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 Month, Day, Year p.m.		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 <u>1952</u> to <u>Jan 1960</u> and last saw ^{her} <u>him</u> alive on <u>1-2-60</u> Death occurred at <u>4 AM</u> on the date stated above, and to the best of my knowledge, from the causes stated.								
22a. SIGNATURE (Degree or title) <u>B. D. Daniel M.D.</u>				22b. ADDRESS <u>Brookfield Mo</u>		22c. DATE SIGNED <u>1-4-60</u>		
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	23b. DATE <u>1-5-60</u>	23c. NAME OF CEMETERY OR CREMATORY <u>ST. MICHAELS CEM</u>		23d. LOCATION (City, town, or county) (State) <u>BROOKFIELD Mo.</u>				
24. FUNERAL DIRECTOR ADDRESS <u>MILLER-Tillotson MARCELINE Mo.</u>			25. DATE RECD. BY LOCAL REG. <u>1-4-60</u>		26. REGISTRAR'S SIGNATURE <u>Katharine Johnson dep</u>			

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me
or by _____, Student Embalmer No. _____
working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed Elburn K. Tidwell

Licensed Embalmer No. 4508

P. O. Address Marceline

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.