

RI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-60-002445

FILED VS JAN 13 1960

187 Primary Registration District No. 3040 Registrar's No. 4

STATE FILE NUMBER

4-14-60
 4-14-60
 None
 accident
 DOCUMENT
 MEDICAL CERTIFICATION
 Coronary Sclerosis, Severe
 blank
 BY AFFIDAVIT OF ~~attending~~ coroner
 18 (b)
 20 (a)

1. PLACE OF DEATH a. COUNTY <u>Lumpkin</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Mo</u> b. COUNTY <u>Lumpkin</u>											
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Chillicothe</u>		Length of stay in lb <u>10 yrs</u>		c. CITY OR TOWN <u>Chillicothe</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>T Jackson St</u>			Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location) <u>3rd st</u>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>								
3. NAME OF DECEASED (Type or print) First Middle Last <u>THOMAS A HUMPHREYS</u>				4. DATE OF DEATH Month Day Year <u>Jan - 7 60</u>											
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</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>3-17-1892</u>	9. AGE (last birthday) <u>67</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>Retired Railroad Laborer</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>Sullivan Co Mo</u>		11. BIRTHPLACE (City and state or country) <u>USA</u>		12. CITIZEN OF WHAT COUNTRY <u>USA</u>								
13a. FATHER'S NAME <u>E.S. Humphreys</u>			13b. MOTHER'S MAIDEN NAME <u>Martina A Smith</u>			14. NAME OF HUSBAND OR WIFE <u>Gladie Maeke Humphrey</u>									
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <input checked="" type="checkbox"/>			16. SOCIAL SECURITY NO. <u>487-05-8276</u>		17. INFORMANT Address <u>Mo Helen Glademil Chillicothe 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>Fractured Neck</u>								INTERVAL BETWEEN ONSET AND DEATH <u>Instant</u>							
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.				DUE TO (b) <u>Coronary Sclerosis, Severe</u>				DUE TO (c)		2 yrs.					
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 checked="" type="checkbox"/> NO <input 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.) <u>Fell from ladder, struck head on pile of</u>												
20c. TIME OF INJURY Hour <u>7:30</u> a.m. / p.m. Month, Day, Year <u>Jan 7 60</u>		20d. INJURY OCCURRED WHILE AT WORK <input checked="" 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.) <u>Working on new house</u>		20f. CITY, TOWN, OR LOCATION <u>Chillicothe</u>							
21. I attended the deceased from <u>Home</u> to <u>hospital</u> on <u>Jan 7-60</u> Death occurred at <u>7:30 A</u> on the date stated above, and to the best of my knowledge, from the causes stated.								22a. SIGNATURE (Degree or title) <u>Joseph A. Conrad M.D. (Coroner)</u>				22b. ADDRESS <u>Chillicothe, Mo</u>		22c. DATE SIGNED <u>Jan 7-60</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE <u>1-9-1960</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Humphrey Cem.</u>			23d. LOCATION (City, town, or county) <u>Humphrey Mo</u>			23e. (State)						
24. FUNERAL DIRECTOR <u>PK Raymond Salt mo</u>				25. DATE RECD. BY LOCAL REG. <u>Jan - 7 - 60</u>		26. REGISTRAR'S SIGNATURE <u>Frances B Neill</u>									

JUN 23 1960

JUN 7 1960

MS DEC 27 1960

MAR 31 1960

FEB

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 PK Payne Jr

Licensed Embalmer No. 3400

P. O. Address Galt

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.