

DEPARTMENT OF HEALTH - STANDARD CERTIFICATE OF DEATH

-60-002483

FILED VS JAN 20 1960

STATE FILE NUMBER

Registration District No. 206 Primary Registration District No. 5749 Registrar's No. 20

| | | | | | |
|---|---|---|---|---|--|
| 1. PLACE OF DEATH a. COUNTY <u>Madison</u> b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>2 Miles East of Roselle Mo</u> Length of stay in 1b <u>Life</u> c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Madison</u> c. CITY OR TOWN <u>2 Miles east of Roselle Mo</u> Inside Limits No <input checked="" type="checkbox"/> d. STREET ADDRESS (If outside, give location) Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> | | |
| 3. NAME OF DECEASED First Middle Last <u>Frank J Inman</u> | | | 4. DATE OF DEATH Month Day Year <u>I 3 1960</u> | | |
| 5. SEX <u>male</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>8/31/76</u> | 9. AGE (last birthday) <u>83</u> | IF UNDER 1 YEAR IF UNDER 24 HR Months Days Hours Min. <u>4 3</u> |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Carpenter</u> | | 10b. KIND OF BUSINESS OR INDUSTRY <u>Building</u> | | 11. BIRTHPLACE (City and state or country) <u>Roselle, Mo</u> | |
| 12. CITIZEN OF WHAT COUNTRY <u>US.A.</u> | | 13a. FATHER'S NAME <u>Jesse Inman</u> | | 13b. MOTHER'S MAIDEN NAME <u>Martha Vance</u> | |
| 14. NAME OF HUSBAND OR WIFE <u>Alice Inman Roselle, Mo</u> | | 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> | | 16. SOCIAL SECURITY NO. <u>489-32-8156</u> | |
| 17. INFORMANT <u>Alice Inman Roselle, 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>Myocardial Infarction</u> DUE TO (b) _____ DUE TO (c) <u>Arteriosclerosis</u> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. | | INTERVAL BETWEEN ONSET AND DEATH <u>1 year 5</u> <u>3 year</u> | |
| 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 as 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 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.) | |
| 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 <u>1957</u> to <u>1-3-60</u> and last saw ^{her} him alive on <u>1-3-60</u> . Death occurred at <u>7:15 P.M.</u> m on the date stated above, and to the best of my knowledge, from the causes stated. | | | | | |
| 22a. SIGNATURE (Degree or title) <u>Joseph H. Taylor M.D.</u> | | | 22b. ADDRESS <u>Ironton, Mo.</u> | | 22c. DATE SIGNED <u>1-4-60</u> |
| 23a. BURIAL, CREMATION, OR REMOVAL (Specify) <u>Burial</u> | | 23b. DATE <u>I/5/60</u> | 23c. NAME OF CEMETERY OR CREMATORY <u>Sebastian Cemetery</u> | | 23d. LOCATION (City, town, or county) (State) <u>Rural Highway 72 Mo</u> |
| 24. FUNERAL DIRECTOR ADDRESS <u>C.A. Howell Ironton, Mo.</u> | | | 25. DATE RECD. BY LOCAL REG. <u>JAN. 5 1960</u> | | 26. REGISTRAR'S SIGNATURE <u>LUCILLE WILSON DEP. FLORENCE HICKS</u> |

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

STATEMENT BY LICENSED EMBALMER

JAN 2

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 C. A. Howell

Licensed Embalmer No. 3670

P. O. Address Greentown

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.