

RI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

FILED VS JAN 27 1960 217

3045

6 -60-002567

Registration District No. _____ Primary Registration District No. _____ Registrar's No. _____ STATE FILE NUMBER

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

3. NAME OF DECEASED (Type or print) First Donald Middle F. Last Mahoney			4. DATE OF DEATH Month Jan. Day 16 Year 1960			
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5. SEX Male	6. COLOR OR RACE White	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH 2-27-18	9. AGE (last birthday) 53	IF UNDER 1 YEAR Months 10 Days 25	IF UNDER 24 HR Hours Min.
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Car salesman	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and state or country) Kalamazoo, Mich	12. CITIZEN OF WHAT COUNTRY U.S.A.
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13a. FATHER'S NAME Guy F. Mahoney	13b. MOTHER'S MAIDEN NAME Katherine B. Rau.	14. NAME OF HUSBAND OR WIFE
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, go, or unknown) (If yes, give war or dates of service) No	16. SOCIAL SECURITY NO.	17. INFORMANT Taken from Birth Certificate 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: IMMEDIATE CAUSE (a) Myocardial Infarction DUE TO (b) Coronary occlusion DUE TO (c) _____ Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.		INTERVAL BETWEEN ONSET AND DEATH less than 5 days
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 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
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21. I attended the deceased from **12/17/59** to **1/12/60** and last saw ^{her}him alive on **1/12/60**
Death occurred at **About 8 A.M** on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE R. J. Prozier MD (Print or title)	22b. ADDRESS Charleston Mo.	22c. DATE SIGNED 1/18/60 (State)
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23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE 1-20-60	23c. NAME OF CEMETERY OR CREMATORY Mounts Park	23d. LOCATION (City, town, or county) Lilbourn, Mo.
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24. FUNERAL DIRECTOR Ponder Funeral Home-Lilbourn, Mo. ADDRESS	25. DATE RECD. BY LOCAL REG. 1-22-60	26. REGISTRAR'S SIGNATURE Dorothy B. Hathlow
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DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

JUL 19 1960

0961 T NOPY

0961 6 T RJA
APR 19 1960

MAR 31 1960

0961 T I RJA
APR 14 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 H. Parker*

Licensed Embalmer No. 3367

P. O. Address Belbourn

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.