

RI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-60-002600

FILED VS. JAN 26 1960

Registration District No. 231 Primary Registration District No. 4348 Registrar's No. 6

STATE FILE NUMBER

| | | | | | | | |
|---|--|---|--|---|--|--|---|
| 1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> COUNTY <u>Ralls</u> | | | |
| b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Wellsville</u> | | Length of stay in 1b | | c. CITY OR TOWN <u>Hannibal</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>East Street</u> | | | Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> | d. STREET ADDRESS (If outside, give location) <u>737 Bridge</u> | | | Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> |
| 3. NAME OF DECEASED (Type or print) First Middle Last <u>Permealie Zumalt Flickinger</u> | | | | 4. DATE OF DEATH Month Day Year <u>Jan. 29, 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>May 17, 1886</u> | 9. AGE (last birthday) <u>73</u> | IF UNDER 1 YEAR Months <u>8</u> Days <u>5</u> | IF UNDER 24 HR Hours <u></u> Min. <u></u> |
| 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>at Home</u> | | 11. BIRTHPLACE (City and state or country) <u>Callaway Co., Mo.</u> | | 12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u> |
| 13a. FATHER'S NAME <u>William Coil</u> | | | 13b. MOTHER'S MAIDEN NAME <u>Luesia Wells</u> | | 14. NAME OF HUSBAND OR WIFE <u>Sherman Flickinger</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>None</u> | 17. INFORMANT Address <u>Roy Zumalt, Wellsville, 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>Disease Carcinoma Uterus to cervix</u> | | | | | | | INTERVAL BETWEEN ONSET AND DEATH <u>6 mos.</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) | | | | | | 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 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 <u></u> Month, Day, Year <u></u> a.m. <u></u> p.m. <u></u> | | 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 <u></u> STATE <u></u> | |
| 21. I attended the deceased from <u>Jan 6, 1960</u> to <u>Jan 22, 1960</u> and last saw her <u>Jan 22, 1960</u> alive on <u>Jan 22, 1960</u> Death occurred at <u>Jan 22, 1960 11:30p</u> on the date stated above, and to the best of my knowledge, from the causes stated. | | | | | | | |
| 22a. SIGNATURE (Degree or title) <u>William H. Wells D.D.</u> | | | | 22b. ADDRESS <u>Wellsville Mo</u> | | 22c. DATE SIGNED <u>1/23/60</u> | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | | 23b. DATE <u>1/24, 1960</u> | 23c. NAME OF CEMETERY OR CREMATORY <u>Liberty Cemetery</u> | | 23d. LOCATION (City, town, or county) <u>Callaway Co., Mo</u> | | |
| 24. FUNERAL DIRECTOR <u>K.B. Wells</u> ADDRESS <u>Wellsville, Mo</u> | | | 25. DATE RECD. BY LOCAL REG. <u>1-23-1960</u> | | 26. REGISTRAR'S SIGNATURE <u>Laura B Callaway</u> | | |

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

JUN 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 Howard Myers

Licensed Embalmer No. 4494

P. O. Address Wellsville

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to do 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.