

RI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-60-002657

FILED VS JAN 11 1960

Registration District No. 201 Primary Registration District No. 3048 Registrar's No. 2

STATE FILE NUMBER

DED

1. PLACE OF DEATH a. COUNTY <u>Nodaway</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Nodaway</u>			
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Maryville</u>		Length of stay in 1b <u>3 wks</u>		c. CITY OR TOWN <u>Quitman</u>		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>St Francis Hospital</u>			Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <u>None</u>		Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Georgia</u> Middle <u>McDaniel</u> Last <u>Kelley</u>				4. DATE OF DEATH Month <u>January</u> Day <u>2</u> Year <u>1960</u>			
5. SEX <u>F</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>7/13/1876</u>	9. AGE (last birthday) <u>83</u>	IF UNDER 1 YEAR Months	IF UNDER 24 HR Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>housewife-teacher</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>School</u>		11. BIRTHPLACE (City and state or country) <u>Quitman n Missouri</u>		12. CITIZEN OF WHAT COUNTRY <u>U S</u>	
13a. FATHER'S NAME <u>William Atkinson</u>			13b. MOTHER'S MAIDEN NAME <u>Martha McDaniel</u>		14. NAME OF HUSBAND OR WIFE <u>Charles Kelley</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>-----</u>		17. INFORMANT Address <u>Mrs Mattie Shipley Burl Jct 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>metastatic carcinoma</u>						INTERVAL BETWEEN ONSET AND DEATH <u>2 wks</u>	
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <u>Carcinoma Larynx</u>							
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 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>11:15 A.M.</u> 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>July 1959</u> to <u>Jan 2, 1960</u> and last saw her <u>live</u> on <u>Jan 2, 1960</u> . Death occurred at <u>11:15 A.M.</u> on the date stated above, and to the best of my knowledge, from the causes stated.							
22a. SIGNATURE (Degree or title) <u>G. Edensbee M.D.</u>				22b. ADDRESS <u>Maryville Mo.</u>		22c. DATE SIGNED <u>Jan 4, 1960</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE <u>Jan 5, 1960</u>	23c. NAME OF CEMETERY OR CREMATORY <u>IOOF Cemetery</u>		23d. LOCATION (City, town, or county) <u>Quitman, Mo</u>		(State)	
24. FUNERAL DIRECTOR <u>W. A. ...</u>		ADDRESS <u>Burl. Jct Missouri</u>		25. DATE RECD. BY LOCAL REG. <u>1-4-60</u>	26. REGISTRAR'S SIGNATURE <u>Bens Holt-</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 _____ or by _____, Student Embalmer No. _____ working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed *[Signature]*

Licensed Embalmer No. 2265
P. O. Address *[Signature]*

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.