

DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-60-002686

FILED VS. JAN 28 1960 257

Registration District No. _____ Primary Registration District No. 4391 Registrar's No. 4

STATE FILE NUMBER

IDED

1. PLACE OF DEATH a. COUNTY <u>Osage</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Osage</u>					
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Meta</u>		Length of stay in 1b		c. CITY OR TOWN <u>Meta</u>		Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>			
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>Home</u>			Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>		d. STREET ADDRESS (If outside, give location)		Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First <u>Annie</u> Middle <u>Elizabeth</u> Last <u>Cross</u>				4. DATE OF DEATH Month <u>Jan</u> Day <u>20</u> Year <u>1960</u>					
5. SEX <u>Female</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>10/15/1875</u>	9. AGE (last birthday) <u>84</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>Housewife</u>			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (City and state or country) <u>Miller Co. MO</u>		12. CITIZEN OF WHAT COUNTRY <u>USA</u>		
13a. FATHER'S NAME <u>James Ahart</u>			13b. MOTHER'S MAIDEN NAME <u>--- Jarrett</u>			14. NAME OF HUSBAND OR WIFE <u>Henry Cross</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 <u>Everett Cross</u>			Address <u>Meta, Mo</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY:							INTERVAL BETWEEN ONSET AND DEATH		
IMMEDIATE CAUSE (a) <u>Bronchopneumonia</u>							<u>20 days</u>		
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.							DUE TO (b) <u>Hypertensive Heart Disease</u>		
							<u>Several Year</u>		
DUE TO (c) <u>Generalized Arteriosclerosis</u>							<u>Several 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 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 _____ 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>1950</u> to <u>1-6-60</u> and last saw her/him alive on <u>1-6-60</u> Death occurred at <u>1:35 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>W. E. Humphrey D.O.</u>				22b. ADDRESS <u>Fuscumbia, Mo.</u>			22c. DATE SIGNED <u>1-21-60</u>		
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>burial</u>		23b. DATE <u>1/22/1960</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Clark</u>		23d. LOCATION (City, town, or county) (State) <u>St. Elizabeth, Mo</u>				
24. FUNERAL DIRECTOR'S ADDRESS <u>Hedges Funeral Homes Iberia, Mo</u>				25. DATE RECD. BY LOCAL REG. <u>1-24-60</u>		26. REGISTRAR'S SIGNATURE <u>Mrs. Clyde Marton</u>			

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

JAN 28 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 Walter P. Hedges

Licensed Embalmer No. 4265

P. O. Address Iberia, La.

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.