

JRI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-60-004779

FILED VS FEB 16 1960

Registration District No. 340 Primary Registration District No. 6152 Registrar's No. 10 STATE FILE NUMBER

1. PLACE OF DEATH a. COUNTY <u>Stoddard</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Cape Girardeur</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Dexter Mo. Liberty</u>		Length of stay in 1b <u>12 days</u>	c. CITY OR TOWN <u>Jackson</u> Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF HOSPITAL OR INSTITUTION <u>Green Meadows Nursing Home</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <u>Route # 1</u> Reside on Farm Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>

3. NAME OF DECEASED (Type or print) <u>DORA</u> First <u>M</u> Middle <u>RIVERS</u> Last			4. DATE OF DEATH <u>Jan. 4 1960</u> Month <u>Jan.</u> Day <u>4</u> Year <u>1960</u>		
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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>5/2/1884</u>	9. AGE (last birthday) <u>75</u>	IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	IF UNDER 24 HR Hours <u> </u> Min. <u> </u>
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, or if retired) <u>Housewife</u>	10b. KIND OF BUSINESS OR INDUSTRY <u>Housework</u>	11. BIRTHPLACE (City and state or country) <u>Jackson, Mo.</u>	12. CITIZEN OF WHAT COUNTRY <u>USA</u>
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13a. FATHER'S NAME <u>William Schweer</u>	13b. MOTHER'S MAIDEN NAME <u>Canzada Walker</u>	14. NAME OF HUSBAND OR WIFE <u>Frank Rivers</u>
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO. <u>491 07 3523</u>	17. INFORMANT <u>Ben Schweer</u> Address <u>Jackson Mo.</u>
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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) <u>Acute Myocardial Failure</u> INTERVAL BETWEEN ONSET AND DEATH <u>18 hr.</u>	
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) <u>Mitral Stenosis</u> <u>unknown</u>
	DUE TO (c) <u>Cardio-Vascular-Renal Syndrome</u> <u>unknown</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.)
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20c. TIME OF INJURY Hour <u> </u> s.m. <u> </u> p.m. <u> </u>	Month, Day, Year <u> </u> <u> </u> <u> </u>
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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 <u> </u> COUNTY <u> </u> STATE <u> </u>
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21. I attended the deceased from None to None and last saw her live on None.
Death occurred at 5:20 a.m. on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE <u>[Signature]</u> (Degree or title)	22b. ADDRESS <u>Dexter, Mo.</u>	22c. DATE SIGNED <u>1-11-60</u>
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23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE <u>Jan. 5 1960</u>	23c. NAME OF CEMETERY OR CREMATORY <u>St. Johns</u>	23d. LOCATION (City, town, or county) <u>Jackson, Mo. R#1</u>
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24. FUNERAL DIRECTOR <u>Mc Combs</u> ADDRESS <u>Jackson, Mo.</u>	25. DATE RECD. BY LOCAL REG. <u>2-1-60</u>	26. REGISTRAR'S SIGNATURE <u>[Signature]</u>
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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 Bruce Dockena, Student Embalmer No. 590

working under my personal supervision.

Student Bruce Dockena
Signature of Student Embalmer

Signed B. Meyer

Licensed Embalmer No. 3051

P. O. Address Jackson

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.