

JRI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-60-004790

FILED VS. JAN 25 1960 381

Primary Registration District No. 6183 Registrar's No. 7

STATE FILE NUMBER

1. PLACE OF DEATH a. COUNTY <u>Sullivan</u>			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Mo</u> b. COUNTY <u>Sullivan</u>		
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Melan</u>		Length of stay in 1b <u>8 yrs</u>	c. CITY OR TOWN <u>Humphreys</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>Laguer Rest Home</u>		Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <u>4 mile road</u>		Reside on Farm Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Middle Last <u>CHARLES L ELWOOD</u>			4. DATE OF DEATH Month Day Year <u>1-13-1960</u>		
5. SEX <u>m</u>	6. COLOR OR RACE <u>w</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>10-31-1869</u>	9. AGE (last birthday) <u>90</u>	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Rubber Farmer</u>		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and state or country) <u>Sullivan Co Mo</u>		12. CITIZEN OF WHAT COUNTRY <u>USA</u>
13a. FATHER'S NAME <u>James R. Elwood</u>		13b. MOTHER'S MAIDEN NAME <u>Elysa James</u>		14. NAME OF HUSBAND OR WIFE <u>Alta Johnson Elwood</u>	
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.	17. INFORMANT <u>Myr Ray Callahan Humphreys 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>Cerebral Hemorrhage</u> DUE TO (b) <u>senility</u> DUE TO (c) _____ Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.)					INTERVAL BETWEEN ONSET AND DEATH <u>1-10-60</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 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 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>1-10-60</u> to <u>1-13-60</u> and last saw him ^{then} alive on <u>1-13-60</u> Death occurred at <u>10 PM</u> on the date stated above, and to the best of my knowledge, from the causes stated.					
22a. SIGNATURE <u>Earl Simpson D.O.</u> (Degree or title)			22b. ADDRESS <u>Milan, Mo</u>		22c. DATE SIGNED <u>1-14-60</u>
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE <u>1-15-1960</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Humphreys Cem.</u>		23d. LOCATION (City, town, or county) (State) <u>Humphreys Mo</u>	
24. FUNERAL DIRECTOR <u>PK Payne</u>		ADDRESS <u>San Lalt Mo</u>	25. DATE RECD. BY LOCAL REG. <u>1-15-60</u>	26. REGISTRAR'S SIGNATURE <u>Mrs. M. W. Beckett</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 me
or by _____, Student Embalmer No. _____
working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed PA Payne Jr

Licensed Embalmer No. 3400

P. O. Address Laet

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.