

RI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-60-004967

FILED VS FEB 24 1960

Registration District No. _____ Primary Registration District No. 5017 Registrar's No. 16

STATE FILE NUMBER

IDED

1. PLACE OF DEATH				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)			
a. COUNTY Andrew		b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Rural: Nodaway Twp.		a. STATE Mo.		b. COUNTY Andrew	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION 1/4 mile North of Savannah		Length of stay in 1b 1 year 6 mo.		c. CITY OR TOWN Savannah		Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>		d. STREET ADDRESS R. R. #1		(If outside, give location)		Reside on Farm Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print)				4. DATE OF DEATH			
First CORA		Middle ALICE		Last PRICE		Month Day Year Feb. 14, 1960	
5. SEX female	6. COLOR OR RACE white	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH 9/14/1873	9. AGE (last birthday) 86	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) Ret. propretor		10b. KIND OF BUSINESS OR INDUSTRY Hotel		11. BIRTHPLACE (City and state or country) Jonesburg, Tenn.		12. CITIZEN OF WHAT COUNTRY USA	
13a. FATHER'S NAME John Miller			13b. MOTHER'S MAIDEN NAME Catherine May			14. NAME OF HUSBAND OR WIFE William	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO. 495-38-9248A		17. INFORMANT Address Mrs. Owen Wasson, R.R. #1, Savannah, Mo.			
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) Influenza						4 days.	
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. due to (b) Cerebral Accident (old)						2 years.	
DUE TO (c) Cardio Vascular Renal Disease -						10 years.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) Arterio-sclerotic Generalized						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 7-10-56 to 2-14-60 and last saw him alive on 2-14-60 Death occurred at 10:15p. m on the date stated above, and to the best of my knowledge, from the causes stated.							
22a. SIGNATURE (Degree or title) Herbert S. Hillebrand				22b. ADDRESS Savannah, Mo.		22c. DATE SIGNED 2-16-60	
23a. BURIAL, CREMATION, REMOVAL (Specify) burial	23b. DATE 2/17/1960	23c. NAME OF CEMETERY OR CREMATORY Savannah Cemetery		23d. LOCATION (City, town, or county) Savannah, Missouri		(State)	
24. FUNERAL DIRECTOR Hector Bowman, St. Joseph, Mo.			25. DATE RECD. BY LOCAL REG. 2-18-60		26. REGISTRAR'S SIGNATURE Lillian Sparks		

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 Ernest Wood

Licensed Embalmer No. 3804

P. O. Address 319 So 10th St

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