

JRI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

FILED VS. FEB. 16 1960 27

-60-005072

STATE FILE NUMBER

Registration District No. Primary Registration District No. 5096 Registrar's No. 30

1. PLACE OF DEATH a. COUNTY <b>Bates</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Missouri</b> b. COUNTY <b>Bates</b>				
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>Mt. Pleasant Twp</b>		Length of stay in 1b <b>6 days</b>		c. CITY OR TOWN <b>Rockville</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>Pine Tree Rest Home</b>			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 <b>MARTHA</b> Middle <b>FOX</b> Last <b>FOX</b>				4. DATE OF DEATH <b>February 5 1960</b> Month <b>February</b> Day <b>5</b> Year <b>1960</b>				
5. SEX <b>female</b>	6. COLOR OR RACE <b>white</b>	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>		8. DATE OF BIRTH <b>9/8/94</b>	9. AGE (last birthday) <b>65</b>	IF UNDER 1 YEAR Months <input type="checkbox"/> Days <input type="checkbox"/>	IF UNDER 24 HR Hours <input type="checkbox"/> Min. <input type="checkbox"/>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>own home</b>		11. BIRTHPLACE (City and state or country) <b>Cedar County, Mo.</b>		12. CITIZEN OF WHAT COUNTRY <b>USA</b>		
13a. FATHER'S NAME <b>Creighton Dodson</b>			13b. MOTHER'S MAIDEN NAME <b>Mary Barnard</b>		14. NAME OF HUSBAND OR WIFE <b>Wray Fox</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>no</b>		16. SOCIAL SECURITY NO. <b>none</b>		17. INFORMANT Address <b>Wray Fox-Rockville, Missouri</b>				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Stroke of Lung</b>						INTERVAL BETWEEN ONSET AND DEATH <b>2 hrs</b>		
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) _____ 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 _____ 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 <b>Jan 1955</b> to <b>Sept 5 1960</b> and last saw her <sup>her</sup> <del>when</del> alive on <b>Jan 1 1960</b> Death occurred at <b>4:30 PM</b> on the date stated above, and to the best of my knowledge, from the causes stated.								
22a. SIGNATURE (Degree or title) <b>Randall Korney M.D.</b>				22b. ADDRESS <b>Rich Hill, Mo</b>		22c. DATE SIGNED <b>Feb 7 1960</b>		
23a. BURIAL, CREMATION REMOVAL (Specify) <b>burial</b>		23b. DATE <b>2/7/60</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Green Lawn Cemetery</b>		23d. LOCATION (City, town, or county) (State) <b>Rich Hill, Missouri</b>		
24. FUNERAL DIRECTOR ADDRESS <b>Booth Funeral Serv-Rich Hill, Mo.</b>				25. DATE RECD. BY LOCAL REG. <b>Feb. 9-1960</b>		26. REGISTRAR'S SIGNATURE <b>Randall Korney</b>		

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

0001 2

REC'D

**STATEMENT BY LICENSED EMBALMER**

**MAR 1**

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 Robert G. Steinbeck

Licensed Embalmer No. 4657

P. O. Address Butler, 1

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.