

RI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-60-005344

FILED VS MAR 7 1960

Registration District No. 47 Primary Registration District No. 3008 Registrar's No. 64

STATE FILE NUMBER

1. PLACE OF DEATH a. COUNTY <u>CALLAWAY</u>		2. USUAL RESIDENCE (Where deceased lived ⁵ If institution: Residence before admission) a. STATE <u>MISSOURI</u> COUNTY <u>HOWARD</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>FULTON</u>		Length of stay in 1b <u>3 days</u>	c. CITY OR TOWN <u>SLATER</u>
c. FULL NAME OF HOSPITAL OR INSTITUTION <u>STATE HOSP. NO. 1</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input 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 Middle Last <u>RAYMOND CORBA CHENEY</u>			4. DATE OF DEATH Month Day Year <u>Feb. 24 1960</u>			
5. SEX <u>MALE</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>Oct. 19, 1885</u>	9. AGE (last birthday) <u>74 yrs.</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>SWITCHMAN</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>SAME</u>		11. BIRTHPLACE (City, and state or country) <u>CENTRALIA MO.</u>		12. CITIZEN OF WHAT COUNTRY <u>UNITED STATES</u>
13a. FATHER'S NAME <u>UNKNOWN</u>		13b. MOTHER'S MAIDEN NAME <u>UNKNOWN</u>		14. NAME OF HUSBAND OR WIFE <u>UNKNOWN</u>		

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>UNKNOWN</u>	16. SOCIAL SECURITY NO. <u>DK.</u>	17. INFORMANT Address <u>HENRY J. GABB SLATER, 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>CARDIO-RESPIRATORY FAILURE</u> INTERVAL BETWEEN ONSET AND DEATH <u>2 days</u>	
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) <u>MYOCARDIAL INFARCTION</u> <u>2-3 yrs.</u>
	DUE TO (c) <u>ARTERIOSCLEROTIC HEART DIS.</u> <u>100 yrs.</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>CHRONIC BRAIN SYNDROME</u>	
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 Feb. 21, 1960, to Feb. 24, 1960 and last saw her/him alive on Feb. 24, 1960
Death occurred at two o'clock a. m. on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) <u>W. J. Freund M.D.</u>	22b. ADDRESS <u>Fulton, Mo</u>	22c. DATE SIGNED <u>24-Feb-60</u>
--	-----------------------------------	--------------------------------------

23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL-Removal-2-24-60</u>	23b. DATE <u>2-24-60</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Slater Cemetery</u>	23d. LOCATION (City, town, or county) (State) <u>SLATER MO.</u>
--	-----------------------------	--	--

24. FUNERAL DIRECTOR ADDRESS <u>Orangin Funeral Home, Fulton, Mo.</u>	25. DATE RECD. BY LOCAL REG. <u>Feb. 27, 1960</u>	26. REGISTRAR'S SIGNATURE <u>Martha Lawrence</u>
--	--	---

(Licensed Embalmer's Statement on Reverse Side)

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF.

MAR 7 1960

STATEMENT BY LICENSED EMBALMER MAR 15 1960

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

Signature Marshall C. Black

Licensed Embalmer No. 4713

P. O. Address Fulton, Ga.

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