

JRI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-60-005358

FILED VS. MAR 15 1960 47

Registration District No. 47 Primary Registration District No. 3008 Registrar's No. 84

STATE FILE NUMBER

1. PLACE OF DEATH a. COUNTY <u>Callaway</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Callaway</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>Fulton</u>	Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (if NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>State Hospital No. 1</u>		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (if outside, give location) <u>821 Westminster</u>
			Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>

3. NAME OF DECEASED (Type or print) First <u>Raymond</u> Middle <u>Nelson</u> Last <u>Nelson</u>			4. DATE OF DEATH Month <u>March</u> Day <u>11</u> Year <u>1960</u>		
5. SEX <u>Male</u>	6. COLOR OR RACE <u>Negro</u>	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/> <u>unknown</u>	8. DATE OF BIRTH <u>1886</u>	9. AGE (last birthday) <u>73</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>retired</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>unknown</u>	11. BIRTHPLACE (City and state or country) <u>unknown</u>	12. CITIZEN OF WHAT COUNTRY <u>unknown</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>unknown</u>	17. INFORMANT Address <u>State Hospital No. 1 Fulton, 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:		INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a) <u>Cerebral Hemorrhage</u>		
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) <u>Hypertension</u>	
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	
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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.)
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20c. TIME OF INJURY Hour <u>3</u> Month <u>9</u> Day <u>6</u> Year <u>60</u> a.m. p.m.	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.) <u>State Hospital No. 1</u>	20f. CITY, TOWN, OR LOCATION <u>Fulton</u>	COUNTY <u>Callaway</u>	STATE <u>Missouri</u>
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21. X attended the deceased from <u>State Hospital No. 1</u> <u>3-9-60</u> to <u>3-11-60</u>	
Death occurred at <u>4:40 A.M.</u> on the date stated above, and to the best of my knowledge, from the causes stated.	

22a. SIGNATURE <u>William F. Farwell M.D.</u> (Degree or title)	22b. ADDRESS <u>Fulton, Mo.</u>	22c. DATE SIGNED <u>3-11-60</u>
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23a. BURIAL, CREMATION, REMOVAL (Specify) <u>3/14/60</u>	23b. DATE <u>3/14/60</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Anatomical Board</u>	23d. LOCATION (City, town, or county) <u>Columbia</u>	(State) <u>Mo.</u>
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24. FUNERAL DIRECTOR <u>Robert Johnston</u>	ADDRESS <u>Columbia, Mo.</u>	25. DATE RECD. BY LOCAL REG. <u>March 14-1960</u>	26. REGISTRAR'S SIGNATURE <u>Maretha Lawrence</u>
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(Licensed Embalmer's Statement on Reverse Side)

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

VS DEC 12 1960

**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 \_\_\_\_\_

Licensed Embalmer No. \_\_\_\_\_

P. O. Address \_\_\_\_\_

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.