

JRI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-60-005436
STATE FILE NUMBER

FILED VS MAR 10 1960

Registration District No. 55 Primary Registration District No. 30 H Registrar's No. 21

INDEXED

1. PLACE OF DEATH a. COUNTY <u>Carroll</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Carroll</u>									
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Carrollton Township</u>		Length of stay in 1b <u>5 months</u>		c. CITY OR TOWN <u>Wakenda Missouri</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>Lancaster Rest Home</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 <u>Lillian</u> Middle <u>O F F U T</u> Last <u>Clements</u>				4. DATE OF DEATH Month <u>Feb.</u> Day <u>24</u> Year <u>1960</u>									
5. SEX <u>Female</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>Aug 28 1878</u>		9. AGE (last birthday) <u>81</u>		IF UNDER 1 YEAR Months <u>5</u> Days <u>26</u> Hours <u></u> Min. <u></u>		IF UNDER 24 HR Hours <u></u> Min. <u></u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>House work</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>House Work.</u>		11. BIRTHPLACE (City and state or country) <u>Camden Missouri</u>		12. CITIZEN OF WHAT COUNTRY <u>U. S. A.</u>					
13a. FATHER'S NAME <u>James Offutt</u>				13b. MOTHER'S MAIDEN NAME <u>Rachel Palmer</u>				14. NAME OF HUSBAND OR WIFE <u>John Clements (Deceased)</u>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>no</u>				16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT Address <u>Madine Keltner Enid Oklahoma</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 Thrombosis</u>										INTERVAL BETWEEN ONSET AND DEATH <u>6-7 months</u>			
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 <u>Sept. 1959</u> to <u>February 24, 1960</u> and last saw her alive on <u>Feb 20, 1960</u> Death occurred at _____ m on the date stated above, and to the best of my knowledge, from the causes stated.													
22a. SIGNATURE <u>John H. Platy</u> (Degree or title) <u>M.D.</u>				22b. ADDRESS <u>Carrollton, Mo</u>				22c. DATE SIGNED <u>2/26/60</u> (State)					
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE <u>2-26-60</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Oak Hill Cemetery</u>		23d. LOCATION (City, town, or county) <u>Carrollton Mo.</u>							
24. FUNERAL DIRECTOR <u>Marshall Funeral Home</u> ADDRESS <u>Carrollton Mo</u>				25. DATE RECD. BY LOCAL REG. <u>2/26/60</u>		26. REGISTRAR'S SIGNATURE <u>Mr. Herbert Calvert</u>							

(Licensed Embalmer's Statement on Reverse Side)

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 R. M. Marshall

Licensed Embalmer No. 2525

P. O. Address Carrollton

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.