

RI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-60-005450

FILED VS MAR 10 1960

Registration District No. 59 Primary Registration District No. 4097 Registrar's No. 55 STATE FILE NUMBER

1. PLACE OF DEATH a. COUNTY <u>CASS</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MISSOURI</u> b. COUNTY <u>CASS</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>HARRISONVILLE</u>		c. CITY OR TOWN <u>HARRISONVILLE</u>	
Length of stay in 7b <u>13 yrs</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>802 W Mechanic</u>		d. STREET ADDRESS (If outside, give location) <u>802 W Mechanic</u>	
Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	

3. NAME OF DECEASED (Type or print) First <u>JESSE</u> Middle <u>OTTO</u> Last <u>TRIBBY</u>			4. DATE OF DEATH Month <u>Feb</u> Day <u>27</u> Year <u>1960</u>		
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. Married <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <u>11-16-1891</u>	9. AGE (last birthday) <u>68</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>laborer</u>		10b. KIND OF BUSINESS OR INDUSTRY _____	11. BIRTHPLACE (City and state or country) <u>PAOLA, KANSAS</u>	12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>	
13a. FATHER'S NAME <u>MARK E. TRIBBY</u>		13b. MOTHER'S MAIDEN NAME <u>KATY SLOAN</u>		14. NAME OF HUSBAND OR WIFE <u>None</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>no</u>		17. INFORMANT <u>Miss Jannice Tribby</u> Address <u>802 W Mechanic Harrisonville, 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>MITRAL REGURGATATION- CARDIAC COLLAPSE</u>		INTERVAL BETWEEN ONSET AND DEATH
DUE TO (b) <u>ARTERIAL HYPERTENSION</u>		
DUE TO (c) <u>GASTRIC HERNIA</u>		
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 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 <u>HARRISONVILLE, MO</u>	COUNTY _____ STATE _____
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21. I attended the deceased from JANUARY 12 1960 to FEBRUARY 27 1960 and last saw him alive on FEB. 25 1960
Death occurred at 6:30 P. m on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE <u>David J. Long, M.D.</u> (Degree or title)	22b. ADDRESS <u>LONG BLDG., HARRISONVILLE, MO</u>	22c. DATE SIGNED
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23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	23b. DATE <u>3-1-1960</u>	23c. NAME OF CEMETERY OR CREMATORY <u>FREEMAN CEMETERY</u>	23d. LOCATION (City, town, or county) (State) <u>FREEMAN, MISSOURI</u>
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24. FUNERAL DIRECTOR <u>ATKINSON-DICKY</u> ADDRESS <u>HARRISONVILLE, MO</u>	25. DATE RECD. BY LOCAL REG. <u>MAR 3-1960</u>	26. REGISTRAR'S SIGNATURE <u>Mrs Ray Sebes</u>
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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 Robert W. Atkins

Licensed Embalmer No. 4902

P. O. Address Harrison

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.