

JRI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-60-005462

FILED VS MAR 2 1960 59

Registration District No. _____ Primary Registration District No. _____ Registrar's No. 50

STATE FILE NUMBER

NDED

1. PLACE OF DEATH a. COUNTY Cass				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri COUNTY Cass					
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN East Lynne		Length of stay in 1b 16 months		c. CITY OR TOWN East Lynne		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>			
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION			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 WILLIAM ALLEN MASTIN				4. DATE OF DEATH Month Day Year Feb. 24 1960					
5. SEX Male	6. COLOR OR RACE White	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>		8. DATE OF BIRTH 3/25/77	9. AGE (last birthday) 82	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) Farmer			10b. KIND OF BUSINESS OR INDUSTRY x		11. BIRTHPLACE (City and state or country) Garland, Mo.		12. CITIZEN OF WHAT COUNTRY U.S.A.		
13a. FATHER'S NAME Unknown			13b. MOTHER'S MAIDEN NAME Unknown			14. NAME OF HUSBAND OR WIFE Betty Mastin			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no			16. SOCIAL SECURITY NO. none		17. INFORMANT Address Opal Knight, East Lynne, Mo.				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bronchopneumonia								INTERVAL BETWEEN ONSET AND DEATH 6 DAYS	
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.		DUE TO (b) Cerebral Thrombosis						3 MOS	
		DUE TO (c) Diabetes Mellitus						2 YRS	
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 Month, Day, Year 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.)		20f. CITY, TOWN, OR LOCATION		COUNTY		STATE	
21. I attended the deceased from JAN 10 1960 to FEB 24 1960 and last saw him alive on FEB 17 1960 Death occurred at HOME #1 12:45 A.M. on the date stated above, and to the best of my knowledge, from the causes stated.									
22a. SIGNATURE McRay MS (Degree or title)				22b. ADDRESS HARRISONVILLE Mo.				22c. DATE SIGNED 2-26-60	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 2/26/60		23c. NAME OF CEMETERY OR CREMATORY Carpenter		23d. LOCATION (City, town, or county) (State) Chilhowee, Mo.			
24. FUNERAL DIRECTOR ADDRESS Cook Funeral Home, Chilhowee, Mo.				25. DATE RECD. BY LOCAL REG. 2-25-60		26. REGISTRAR'S SIGNATURE McRay Sebra			

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 me
or by _____, Student Embalmer No. _____
working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed _____

Jacobs

Licensed Embalmer No. 4335

P.O. Address Chilhoway

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.