

FRI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

60-005699

FILED VS MAR 7 1960

Registration District No. 100 Primary Registration District No. 3018 Registrar's No. 21 STATE FILE NUMBER

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1. PLACE OF DEATH a. COUNTY Dent		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY Dent	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Salem	Length of stay in 1b Years	c. CITY OR TOWN Salem	Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (IF NOT in hospital, give location) HOSPITAL OR INSTITUTION 314 S. Jackson St.		d. STREET ADDRESS (If outside, give location) 314 S. Jackson St.	Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print) First CLYDE Middle MILTON Last DOUGLASS			4. DATE OF DEATH Month March Day 3 Year 1960		
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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 6/10/1880	9. AGE (last birthday) 79	IF UNDER 1 YEAR Months <input type="checkbox"/> Days <input type="checkbox"/>	IF UNDER 24 HR Hours <input type="checkbox"/> Min. <input type="checkbox"/>
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Proprietor	10b. KIND OF BUSINESS OR INDUSTRY Resturant	11. BIRTHPLACE (City and state or country) Burlington Kansas	12. CITIZEN OF WHAT COUNTRY U.S.A.
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13a. FATHER'S NAME Dr. Robert P. Douglass	13b. MOTHER'S MAIDEN NAME Clara Olive Prouty	14. NAME OF HUSBAND OR WIFE Olive Mae
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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. 488-38-0182	17. INFORMANT Olive Mae Douglass Salem, Mo.
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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: IMMEDIATE CAUSE (a) BRONCHIAL PNEUMONIA		INTERVAL BETWEEN ONSET AND DEATH 3 DAYS
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) INFLUENZA	9 DAYS
	DUE TO (c)	

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) CHRONIC PARKINSONISM - CHRONIC ARTHRITIS	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.) 710 - injury
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20c. TIME OF INJURY Hour <input type="checkbox"/> a.m. <input type="checkbox"/> p.m.	Month, Day, Year 3/2/60
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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.) 8712/55	20f. CITY, TOWN, OR LOCATION Salem	COUNTY Missouri	STATE
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21. I attended the deceased from 8/12/55 to 3/2/60 and last saw him alive on 3/2/60 Death occurred at 8:00 A m on the date stated above, and to the best of my knowledge, from the causes stated.
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22a. SIGNATURE (Degree or title) L.H. Hunt M.D.	22b. ADDRESS Salem, Mo.	22c. DATE SIGNED 3/4/60
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23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE 3/6/1960	23c. NAME OF CEMETERY OR CREMATORY Cedar Grove Cemetery	23d. LOCATION (City, town, or county) Salem Missouri
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24. FUNERAL DIRECTOR Max L. Warfel	ADDRESS Salem, Mo.	25. DATE RECD. BY LOCAL REG. 3/5/60	26. REGISTRAR'S SIGNATURE M. M. Hart M.D.
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(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 Max L. Warf

Licensed Embalmer No. 4170

P. O. Address Salem, Va

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.