

URI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

FILED VS MAR 15 1960

-60-005753

STATE FILE NUMBER

Registration District No. 114 Primary Registration District No. 4186 Registrar's No. 8

ENDED

1. PLACE OF DEATH a. COUNTY <u>Franklin</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Mo.</u> b. COUNTY <u>Franklin</u>			
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Sullivan Mo.</u>		Length of stay in 1b <u>87 yrs</u>		c. CITY OR TOWN <u>Sullivan Mo.</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>429 N. Mansion</u>			Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <u>429 N. Mansion</u>			Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <u>Melvina</u> Middle <u>C</u> Last <u>Dotter</u>				4. DATE OF DEATH Month <u>March</u> Day <u>10</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>Oct. 28 1872</u>	9. AGE (last birthday) <u>87</u>	IF UNDER 1 YEAR Months <u></u> Days <u></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-wife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>none</u>		11. BIRTHPLACE (City and state or country) <u>Franklin County Mo.</u>		12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>	
13a. FATHER'S NAME <u>James A Crockett</u>			13b. MOTHER'S MAIDEN NAME <u>Caroline Korte</u>		14. NAME OF HUSBAND OR WIFE <u>Samuel A Dotter</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>L.N. Dotter Sullivan 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>Cirrhosis of Liver</u>						INTERVAL BETWEEN ONSET AND DEATH <u>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) <u>Banti's Syndrome - SPLENOMEGALY - NEUTROPENIA - CIRRHOSIS</u>						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		COUNTY	STATE
21. I attended the deceased from _____ to <u>Mar 1960</u> and last saw her alive on <u>Mar 8 - 1960</u> . Death occurred at <u>700 A.</u> on the date stated above, and to the best of my knowledge, from the causes stated.							
22a. SIGNATURE (Degree or title) <u>Robert M. Gray</u>			22b. ADDRESS <u>Sullivan Missouri</u>		22c. DATE SIGNED <u>Mar 10 1960</u>		
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE <u>Mar. 12 1960</u>	23c. NAME OF CEMETERY OR CREMATORY <u>I.O.O.F.</u>		23d. LOCATION (City, town, or county) <u>Sullivan Mo.</u>		(State)	
24. FUNERAL DIRECTOR ADDRESS <u>Thos. P. Shaffer Sullivan Mo.</u>			25. DATE RECD. BY LOCAL REG. <u>3-11-60</u>	26. REGISTRAR'S SIGNATURE <u>Thomas A. Humphrey</u>			

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

STATEMENT BY LICENSED EMBALMER

1001 83 1711

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 P. Shaffer

Licensed Embalmer No. 2192

P. O. Address Sub

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.