

# JRI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

FILED VS MAR 1 1960 139

-60-006046

STATE FILE NUMBER

Registration District No. \_\_\_\_\_ Primary Registration District No. \_\_\_\_\_ Registrar's No. 9

1. PLACE OF DEATH a. COUNTY <b>HOLT</b>			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MISSOURI</b> , COUNTY <b>HOLT</b>			
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>MOUND City</b>		Length of stay in 1b <b>Lifetime</b>	c. CITY OR TOWN <b>MOUND City</b>		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 checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First <b>SARAH</b> Middle <b>MILDRED</b> Last <b>MINSHALL</b>			4. DATE OF DEATH <b>FEB 21, 1960</b> Month Day Year			
5. SEX <b>FEMALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <b>11/18/1873</b>	9. AGE (last birthday) <b>86</b>	IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOUSEWIFE</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>IN THE HOME</b>	11. BIRTHPLACE (City and state or country) <b>HOLT Co., Mo.</b>	12. CITIZEN OF WHAT COUNTRY <b>U.S.A.</b>		
13a. FATHER'S NAME <b>WILLIAM J. FIELD</b>		13b. MOTHER'S MAIDEN NAME <b>MARY E. LEUSENAL</b>		14. NAME OF HUSBAND OR WIFE <b>ZIMMER MINSHALL</b>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, (unknown) (If yes, give war or dates of service) <b>NO</b>		16. SOCIAL SECURITY NO. <b>NONE</b>	17. INFORMANT <b>IDA M. INTYRE, MOUND City, Mo.</b> Address			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY:					INTERVAL BETWEEN ONSET AND DEATH	
IMMEDIATE CAUSE (a) <b>UREMIA</b>					<b>3 months</b>	
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <b>CHRONIC GLOMERULO NEPHRITIS</b>					<b>Many years.</b>	
DUE TO (c) <b>DIABETES MELLITUS</b>					<b>Many years.</b>	
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 checked="" 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 <b>Dec. 1959</b> to <b>Feb. 21, 1960</b> and last saw <b>her</b> alive on <b>Feb. 21, 1960</b> Death occurred at <b>2 AM</b> on the date stated above, and to the best of my knowledge, from the causes stated.						
22a. SIGNATURE (Degree or title) <b>James Humphrey M.D.</b>			22b. ADDRESS <b>MOUND CITY, Mo.</b>		22c. DATE SIGNED <b>Feb. 24, 1960</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>	23b. DATE <b>2/24/1960</b>	23c. NAME OF CEMETERY OR CREMATORY <b>DENTON CEMETERY</b>	23d. LOCATION (City, town, or county) (State) <b>MOUND City, Mo.</b>			
24. FUNERAL DIRECTOR <b>James H. Crawford - MOUND City, Mo.</b>		ADDRESS	25. DATE RECD. BY LOCAL REG. <b>2/24/1960</b>	26. REGISTRAR'S SIGNATURE <b>James Crawford</b>		

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 *James H. Crawford*

Licensed Embalmer No. 4796

P. O. Address Trinidad, C.

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.