

JRI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-60-006066

FILED VS. FEB 20 1960 140

Registration District No. 140

Primary Registration District No. 3024

Registrar's No. 18

STATE FILE NUMBER

| | | | | | | | |
|---|--|---|--|--|---|---|--|
| 1. PLACE OF DEATH a. COUNTY Howard | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri COUNTY Howard | | | |
| b. CITY (if outside corporate limits, give TOWNSHIP only) OR TOWN Fayette, Mo. | | Length of stay in lb 6 months | | c. CITY OR TOWN Fayette | | Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> | |
| c. FULL NAME OF (IF NOT in hospital, give location) HOSPITAL OR INSTITUTION Wells Rest Haven | | | Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> | d. STREET ADDRESS (if outside, give location) Boone Femme Twp. | | Reside on Farm Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) First ANNIE Middle BLANCHE Last WHITE | | | | 4. DATE OF DEATH Month FEB. Day 16, Year 1960 | | | |
| 5. SEX Female | 6. COLOR OR RACE White | 7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/> | | 8. DATE OF BIRTH 10/26/1873 | 9. AGE (last birthday) 86 | IF UNDER 1 YEAR Months <input type="checkbox"/> Days <input type="checkbox"/> | IF UNDER 24 HR Hours <input type="checkbox"/> Min. <input type="checkbox"/> |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House work | | 10b. KIND OF BUSINESS OR INDUSTRY Own Home | | 11. BIRTHPLACE (City and state or country) Howard County, Mo. | | 12. CITIZEN OF WHAT COUNTRY U.S.A. | |
| 13a. FATHER'S NAME Zach Crews | | | 13b. MOTHER'S MAIDEN NAME Matilda Ann Means | | 14. NAME OF HUSBAND OR WIFE William Stone White | | |
| 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 Mrs Margaret McKee Fayette, Mo. Address | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Thrombosis DUE TO (b) Chronic Arteriosclerosis DUE TO (c) 5 years Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. | | | | | | INTERVAL BETWEEN ONSET AND DEATH 5 years | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) Cancer of Cervix | | | | | 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 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 <input type="checkbox"/> a.m. <input type="checkbox"/> 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 1-1-60 to 2-16-60 and last saw her alive on 2-16-60 Death occurred at 7:00 P.m. on the date stated above, and to the best of my knowledge, from the causes stated. | | | | | | | |
| 22a. SIGNATURE W. Bloom M.D. (Degree or title) | | | 22b. ADDRESS Fayette Mo. | | | 22c. DATE SIGNED 2-16-60 | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial | 23b. DATE 2/18/1960 | 23c. NAME OF CEMETERY OR CREMATORY Walnut Ridge Cemetery | | 23d. LOCATION (City, town, or county) Fayette, Missouri (State) | | | |
| 24. FUNERAL DIRECTOR Kalish A. Carr ADDRESS Fayette, Mo. | | 25. DATE RECD. BY LOCAL REG. 2-26-60 | | 26. REGISTRAR'S SIGNATURE Katherine Welsh | | | |

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

Ralph A. Carl

Licensed Embalmer No. 3340

P. O. Address Fayette,

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.