URI DIVISION OF HEALTH — STANDARD CERTIFICATE OF DEATH

-60-006076

FILED VS MAR 7 1960

STATE FILE NUMBER

Registration District No. 141 Primary Registration District No. 3025 Registrar's No. 40

ENDED

1. PLACE OF DEATH
a. COUNTY Howell
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN West Plains — Length of stay in 1b: mos
c. FULL NAME OF HOSPITAL OR INSTITUTION (If NOT in hospital, give location): Luna Nursing Home — Inside Limits: Yes ☑ No ☐

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Mo. b. COUNTY Howell
c. CITY OR TOWN West Plains — Inside Limits: Yes ☑ No ☐
d. STREET ADDRESS (If outside, give location) ✓ ✓ — Reside on Farm: Yes ☐ No ☑

3. NAME OF DECEASED (Type or print): First Lieu Middle E. Last Jolliff
4. DATE OF DEATH: Month 2 Day 18 Year 60
5. SEX: F
6. COLOR OR RACE: W
7. Married ☐ Never Married ☐ Widowed ☑ Divorced ☐
8. DATE OF BIRTH: 10-4-76
9. AGE (last birthday): 83 — 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): Hwifw
10b. KIND OF BUSINESS OR INDUSTRY: ✓
11. BIRTHPLACE (City and state or country): Tennessee
12. CITIZEN OF WHAT COUNTRY: USA
13a. FATHER'S NAME: W. M. Cropper
13b. MOTHER'S MAIDEN NAME: Martha Russell
14. NAME OF HUSBAND OR WIFE: ✓ ✓
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) ✓ (If yes, give war or dates of service) ✓
16. SOCIAL SECURITY NO.: ✓
17. INFORMANT: D. L. Russell, Address: Caulfield Mo

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): Peripheral Vascular Disease with Gangrene of RT Foot
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.
DUE TO (b): Generalized Arteriosclerosis
Cardiac Decompensation
DUE TO (c): Hypertension, Chr. Moderate
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. ☐ Yes ☐ No ☒ ☐ Unknown

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒
20a. ACCIDENT ☐ SUICIDE ☐ HOMICIDE ☐
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 ☐ NOT WHILE AT WORK ☐
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 17-3-52, to 18-2-60 and last saw her alive on 14-2-60
Death occurred at 6:45 A m on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title): [signature] M.D.
22b. ADDRESS: West Plains, Mo
22c. DATE SIGNED: 23/2/60

23a. BURIAL, CREMATION, REMOVAL (Specify): JB
23b. DATE: 2-22-60
23c. NAME OF CEMETERY OR CREMATORY: Martin
23d. LOCATION (City, town, or county) (State): Dora Mo

24. FUNERAL DIRECTOR: Robertson — ADDRESS: West Plains Mo
25. DATE RECD. BY LOCAL REG.: 2-29-60
26. REGISTRAR'S SIGNATURE: [signature] Beatrice Cook

(Licensed Embalmer's Statement on Reverse Side)

MEDICAL CERTIFICATION

BY AFFIDAVIT OF DOCUMENT

MAR 8

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 _____ Signed _____

Signature of Student Embalmer

Licensed Embalmer No. 34-32

P. O. Address _____

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to co 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.