

JRI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-60-006085

FILED VS FEB 29 1960

Registration District No. 141 Primary Registration District No. 5551 Registrar's No. 33

STATE FILE NUMBER

1. PLACE OF DEATH a. COUNTY <u>Nowell</u>				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Mo</u> b. COUNTY <u>Nowell</u>				
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>West Plains</u>		Length of stay in lb <u>7 yrs</u>		c. CITY OR TOWN <u>West Plains</u>		Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>		
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>Rte 2</u>			Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>		d. STREET ADDRESS (If outside, give location) <u>Rte 2</u>		Reside on Farm Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Ella M.</u> Middle <u>Irvin</u> Last				4. DATE OF DEATH Month <u>1</u> Day <u>25</u> Year <u>60</u>				
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</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>2-3-82</u>	9. AGE (last birthday) <u>77</u>	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HR Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <input checked="" type="checkbox"/>		11. BIRTHPLACE (City, and state or country) <u>Nowell Co., Mo</u>		12. CITIZEN OF WHAT COUNTRY <u>USA</u>		
13. FATHER'S NAME <u>F. J. Shinkle</u>			13b. MOTHER'S MAIDEN NAME <u>Lucinda Cook</u>			14. NAME OF HUSBAND OR WIFE <u>Terrie Hall, West Plains Mo</u>		
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. <u>yes</u>		17. INFORMANT Address <u>Terrie Hall, West Plains 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>Electrolyte imbalance</u>						INTERVAL BETWEEN ONSET AND DEATH <u>2 weeks</u>		
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.		DUE TO (b) <u>Partial obstruction, colon</u>				<u>6 weeks</u>		
		DUE TO (c) <u>Probable malignancy of colon</u>				<u>6 mos.</u>		
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 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 <u>2:05</u> 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 <u>6/11/59</u> to <u>1/25/60</u> and last saw her <u>alive</u> on <u>1/12/60</u> Death occurred at <u>2:05 A.</u> m on the date stated above, and to the best of my knowledge, from the causes stated.								
22a. SIGNATURE (Degree or title) <u>M.L. Fowler MD</u>				22b. ADDRESS <u>West Plains, Mo.</u>		22c. DATE SIGNED <u>2/3/60</u>		
23a. BURIAL, CREMATION, REINTERMENT (Specify) <u>no</u>		23b. DATE <u>1-27-1960</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Cook Lawn</u>		23d. LOCATION (City, town, or county) (State) <u>West Plains Mo</u>			
24. FUNERAL DIRECTOR <u>Robertson Matthews</u>			ADDRESS <u>Mo</u>		25. DATE RECD. BY LOCAL REG. <u>2-24-60</u>	26. REGISTRAR'S SIGNATURE <u>Beatrice Cook</u>		

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 *A. D. Roberts*

Licensed Embalmer No. 343

P. O. Address West Ta

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.