

UNIVERSITY DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-60-006087

FILED MAR 14 1960

Registration District No. 141 Primary Registration District No. 5553 Registrar's No. 44

STATE FILE NUMBER

1. PLACE OF DEATH a. COUNTY Howell				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY Howell					
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN South Fork		Length of stay in 1b 3 1/2 yrs		c. CITY OR TOWN South Fork		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>			
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION			Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location)		Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Sylvia Middle Pearl Last Kennedy				4. DATE OF DEATH Month March Day 7 Year 1960					
5. SEX Female	6. COLOR OR RACE White	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>		8. DATE OF BIRTH	9. AGE (last birthday) 52	IF UNDER 1 YEAR Months	IF UNDER 24 HR Days	Hours	Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife			10b. KIND OF BUSINESS OR INDUSTRY Domestic		11. BIRTHPLACE (City and state or country) Sioux City, Iowa		12. CITIZEN OF WHAT COUNTRY USA		
13a. FATHER'S NAME Carlisle			13b. MOTHER'S MAIDEN NAME Unknown		14. NAME OF HUSBAND OR WIFE William A. Kennedy				
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 Address MO. William A. Kennedy, South Fork,				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pseudomonas cytoplastocarcinoma of left ovary.							INTERVAL BETWEEN ONSET AND DEATH 3 years		
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)						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 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 1956 to 3/7/60 and last saw her him alive on 2/26/60 Death occurred at _____ m on the date stated above, and to the best of my knowledge, from the causes stated.									
22a. SIGNATURE (Degree or title) M-L Fowler MD				22b. ADDRESS West Plains MO			22c. DATE SIGNED 3/9/60		
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE 3-9-60	23c. NAME OF CEMETERY OR CREMATORY Howell Co. Memorial		23d. LOCATION (City, town, or county) (State) Howell County, Missouri					
24. FUNERAL DIRECTION ADDRESS Sealand Center, West Plains, Mo			25. DATE RECD. BY LOCAL REG. 3-11-60		26. REGISTRAR'S SIGNATURE Beatrice Cook				

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

APR 1 1960

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

Douglas P. Gorman

Licensed Embalmer No. 5087

P. O. Address West Pla

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.