

JRI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

FILED VS MAR 3 1960 157

5582

-60-006895

STATE FILE NUMBER

Registration District No. _____ Primary Registration District No. _____ Registrar's No. 48

1. PLACE OF DEATH a. COUNTY Jasper				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Mo. b. COUNTY Jasper									
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Jackson Township		Length of stay in 1b 14 Mos.		c. CITY OR TOWN Carthage		Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>							
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Carthage Rt. 3 Fair Acres			Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>		d. STREET ADDRESS (if outside, give location) Fair Acres Route 3		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>						
3. NAME OF DECEASED (Type or print) First ALBERT Middle F Last KING				4. DATE OF DEATH Month February Day 24 Year 1960									
5. SEX Male		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 11/25/62		9. AGE (last birthday) 97		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) Retired Farmer				10b. KIND OF BUSINESS OR INDUSTRY Farm		11. BIRTHPLACE (City and state or country) Galena, Mo		12. CITIZEN OF WHAT COUNTRY U.S.A.					
13a. FATHER'S NAME unknown				13b. MOTHER'S MAIDEN NAME unknown				14. NAME OF HUSBAND OR WIFE Lucy Carr King					
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 C.O. King, Rte 3, Galena, Mo							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Mycarditis Chronica</i> DUE TO (b) <i>Arteriosclerosis Generalized</i> DUE TO (c) _____ Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.										INTERVAL BETWEEN ONSET AND DEATH <i>unknown</i>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <i>Outset Scurvy</i>										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 _____ 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 12-29-59 to 2-24-60 and last saw him alive on 2-23-60 Death occurred at 12 p.m. on the date stated above, and to the best of my knowledge, from the causes stated.													
22a. SIGNATURE <i>[Signature]</i> (Degree or title) MD				22b. ADDRESS 304 Grant Carthage, Mo				22c. DATE SIGNED 2-24-60 (State)					
23a. BURIAL, CREMATION, REMOVAL (Specify) burial		23b. DATE 2-27-60		23c. NAME OF CEMETERY OR CREMATORY Galena Cemetery		23d. LOCATION (City, town, or county) Galena, Mo							
24. FUNERAL DIRECTOR ADDRESS KNELL MORTUARY Carthage, Mo				25. DATE RECD. BY LOCAL REG. 2-25-60		26. REGISTRAR'S SIGNATURE <i>[Signature]</i>							

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 me
or by _____, Student Embalmer No. _____
working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed Robert H Knell

Licensed Embalmer No. 4459

P. O. Address Carthage

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.