

RI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

=60-006969

FILED VS. FEB 23 1960 164

Registration District No. 164 Primary Registration District No. 3032 Registrar's No. 29

STATE FILE NUMBER

1. PLACE OF DEATH a. COUNTY <u>Johnson</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Johnson</u>			
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Warrensburg</u>		Length of stay in 1b <u>11 days</u>		c. CITY OR TOWN <u>Chilhowee, Missouri</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>Warrensburg Medical Center</u>			Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <u>None</u>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>CLARENCE</u> Middle <u>LEE</u> Last <u>BANCROFT</u>				4. DATE OF DEATH Month <u>February</u> Day <u>15</u> Year <u>1960</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>		8. DATE OF BIRTH <u>5-11-1888</u>	9. AGE (last birthday) <u>71</u>	IF UNDER 1 YEAR Months <u> </u> Days <u> </u>	IF UNDER 24 HR Hours <u> </u> Min. <u> </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Machinist</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>Self Employed</u>		11. BIRTHPLACE (City and state or country) <u>Johnson County, Mo.</u>		12. CITIZEN OF WHAT COUNTRY <u>USA</u>
13a. FATHER'S NAME <u>George M. Bancroft</u>			13b. MOTHER'S MAIDEN NAME <u>Mary L. Miller</u>		14. NAME OF HUSBAND OR WIFE <u>Mrs. Ollie M. Bancroft</u>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>495-20-7799</u>		17. INFORMANT Address <u>Mrs. Ollie M. Bancroft, Chilhowee, 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>Post operative hemorrhage T.U.R.</u>						INTERVAL BETWEEN ONSET AND DEATH <u>12 hrs</u>	
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.						DUE TO (b) _____	
DUE TO (c) _____						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 checked="" 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 <u>Jan 14</u> to <u>2-15-60</u> and last saw ^{see} him alive on <u>2-15-60</u> Death occurred at <u>11:35 A.M.</u> m on the date stated above, and to the best of my knowledge, from the causes stated.							
22a. SIGNATURE (Degree or title) <u>Deed Maxson</u>				22b. ADDRESS <u>Warrensburg, Mo.</u>		22c. DATE SIGNED <u>16 Feb 60</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE <u>2-17-60</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Sunset Hill Cemetery</u>		23d. LOCATION (City, town, or county) (State) <u>Warrensburg, Missouri</u>		
24. FUNERAL DIRECTOR <u>The Brauningers, Warrensburg, Missouri</u>				25. DATE RECD. BY LOCAL REG. <u>Feb 16 1960</u>		26. REGISTRAR'S SIGNATURE <u>Barbara Hutchfield</u> <u>Barbara Hutchfield</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 Robert J. McDonald

Licensed Embalmer No. 482

P. O. Address Warren

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.