

DEPARTMENT OF HEALTH - STANDARD CERTIFICATE OF DEATH

-60-006987

FILED VS MAR 7 1960 69

Registration District No. \_\_\_\_\_ Primary Registration District No. \_\_\_\_\_ Registrar's No. 7

STATE FILE NUMBER

1. PLACE OF DEATH a. COUNTY <b>Knox</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Mo</b> b. COUNTY <b>Knox</b>					
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>Edina</b>		Length of stay in 1b <b>4 weeks</b>		c. CITY OR TOWN <b>Edina</b>		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>			
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>Gibson Hospital</b>			Inside Limits Yes <input checked="" 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 <b>MARY</b> Middle <b>ELLEN</b> Last <b>LOREY</b>				4. DATE OF DEATH <b>Feb 26, 1960</b> Month <b>Feb</b> Day <b>26</b> Year <b>1960</b>					
5. SEX <b>F</b>	6. COLOR OR RACE <b>W</b>	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>		8. DATE OF BIRTH <b>13 Mar 1868</b>	9. AGE (last birthday) <b>92</b>	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) <b>homekeeper</b>			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (City and state or country) <b>Peoria, Illinois</b>		12. CITIZEN OF WHAT COUNTRY <b>USA</b>		
13a. FATHER'S NAME <b>John Nolan</b>			13b. MOTHER'S MAIDEN NAME <b>Mary Kilroy</b>			14. NAME OF HUSBAND OR WIFE <b>William M. Lorey</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>no</b>			16. SOCIAL SECURITY NO. <b>none</b>		17. INFORMANT Address <b>Mrs. Floren Hall LaPlata, Mo</b>				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute Circulatory Failure</b> DUE TO (b) <b>Bronchopneumonia</b> DUE TO (c) <b>Fracture of Rib</b> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.							INTERVAL BETWEEN ONSET AND DEATH		
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 checked="" type="checkbox"/> No <input type="checkbox"/> Unknown			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20a. ACCIDENT <input checked="" 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.) <b>Fell on floor</b>					
20c. TIME OF INJURY Hour _____ a.m. _____ p.m. Month, Day, Year <b>2-1-60</b>		20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <b>Home</b>		20f. CITY, TOWN, OR LOCATION <b>Edina</b>		COUNTY <b>Knox</b>	STATE <b>Mo.</b>
21. I attended the deceased from <b>Feb 1, 1960</b> to <b>Feb 26</b> and last saw her/him alive on <b>Feb 26, 1960</b> . Death occurred at <b>4:20 P.M.</b> on the date stated above, and to the best of my knowledge, from the causes stated.									
22a. SIGNATURE (Degree or title) <b>C. H. Gibson, D.D.</b>					22b. ADDRESS <b>Edina, Mo.</b>		22c. DATE SIGNED <b>2-27-60</b>		
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>burial</b>		23b. DATE <b>29 Feb 60</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Old Catholic Cemetery</b>		23d. LOCATION (City, town, or county) (State) <b>Edina, Missouri</b>				
24. FUNERAL DIRECTOR ADDRESS <b>HUDSON-RIMMER FUNERAL HOME</b> <b>Mo</b>			25. DATE RECD. BY LOCAL REG. <b>Mar-2-1960</b>		26. REGISTRAR'S SIGNATURE <b>W. H. A. ...</b>				

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

*AS Rimm*

Licensed Embalmer No. 5041

P. O. Address Edina, ?

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.