

RI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

60-007001

FILED VS. MAR 8 1960 120

Registration District No. 3033 Registrar's No. 39

STATE FILE NUMBER

1. PLACE OF DEATH a. COUNTY Laclede				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Mo. b. COUNTY Laclede						
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Lebanon		Length of stay in 1b 2 days		c. CITY OR TOWN Lebanon		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>				
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Louise G. Wallace			Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>		d. STREET ADDRESS (If outside, give location) 311 W. Hayes		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Teresa Middle Gayle Last Jones				4. DATE OF DEATH Month Feb Day 24 Year 1960						
5. SEX female	6. COLOR OR RACE white	7. Married <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>		8. DATE OF BIRTH 2-22-60	9. AGE (last birthday) IF UNDER 1 YEAR Months 2 Days 2		IF UNDER 24 HR Hours 2 Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) none			10b. KIND OF BUSINESS OR INDUSTRY none		11. BIRTHPLACE (City and state or country) Lebanon, Mo		12. CITIZEN OF WHAT COUNTRY U.S.A.			
13a. FATHER'S NAME unknown			13b. MOTHER'S MAIDEN NAME Dorothy Jones			14. NAME OF HUSBAND OR WIFE none				
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 Dorothy Jones, 311 W. Hayes, Lebanon, Mo Address						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Prematurity							INTERVAL BETWEEN ONSET AND DEATH			
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 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 _____ Month, Day, Year _____ a.m. _____ p.m. _____		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.) Bath		20f. CITY, TOWN, OR LOCATION Lebanon Mo		COUNTY Mo. STATE	
21. I attended the deceased from Bath to 2/24/60 and last saw her alive on 2/24/60 Death occurred at 6:40 A m on the date stated above, and to the best of my knowledge, from the causes stated.										
22a. SIGNATURE R. Froelich MD (Degree or title)				22b. ADDRESS Lebanon Mo			22c. DATE SIGNED 2/29/60			
23a. BURIAL, CREMATION, REMOVAL (Specify) burial		23b. DATE 2-25-60	23c. NAME OF CEMETERY OR CREMATORY Mt. Rose Memorial Park		23d. LOCATION (City, town, or county) Lebanon, Mo.		(State)			
24. FUNERAL DIRECTOR F. J. Shade ADDRESS Lebanon, Mo.				25. DATE RECD. BY LOCAL REG. 2-29-1960		26. REGISTRAR'S SIGNATURE Hilla L. Gray				

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

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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 not embalmed, Student Embalmer No. _____
working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed _____

Licensed Embalmer No. _____

P. O. Address _____

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.