

JRI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-60-007155

FILED VS FEB 29 1960 385

Registration District No. 385 Primary Registration District No. 3039 Registrar's No. 98

STATE FILE NUMBER

1. PLACE OF DEATH a. COUNTY <u>LINN</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MO</u> b. COUNTY <u>LINN</u>			
b. CITY (if outside corporate limits, give TOWNSHIP only) OR TOWN <u>MARCELINE</u>		Length of stay in 1b <u>1 1/2 yrs.</u>		c. CITY OR TOWN <u>MARCELINE</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>113 E. SANTA FE</u>				Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location) <u>113 E. SANTA FE</u>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>ROSS McALLISTER</u>				4. DATE OF DEATH Month Day Year <u>2/ 7/60</u>			
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</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>8/15/1884</u>	9. AGE (last birthday) <u>75</u>	IF UNDER 1 YEAR Months <u>5</u> Days <u>22</u>	IF UNDER 24 HR Hours <u>22</u> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>CRLAMERY</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>RETIRED</u>		11. BIRTHPLACE (City and state or country) <u>CHARITON, CO</u>		12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>	
13a. FATHER'S NAME <u>BRADFORD</u>			13b. MOTHER'S MAIDEN NAME <u>MALINDA BROWN</u>			14. NAME OF HUSBAND OR WIFE <u>ARMELDA</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>490-10-4227</u>		17. INFORMANT Address <u>Mrs. Ross McAllister</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>Coronary Thrombosis</u> DUE TO (b) <u>Arteriosclerotic Cardio-vasc Dis.</u> DUE TO (c) <u>Hypertension</u> 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 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 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.)		20f. CITY, TOWN, OR LOCATION		COUNTY STATE	
21. I attended the deceased from <u>8:00 p</u> to <u>2-7-60</u> and last saw her him alive on <u>1-9-60</u> Death occurred at <u>5:00 p</u> m on the date stated above, and to the best of my knowledge, from the causes stated.							
22a. SIGNATURE <u>Robert W. James MD</u> (Degree or title)				22b. ADDRESS <u>Marceline, Mo</u>		22c. DATE SIGNED <u>2-8-60</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>B</u>		23b. DATE <u>2/10/60</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Mt. Olivet</u>		23d. LOCATION (City, town, or county) (State) <u>Marceline, Mo</u>	
24. FUNERAL DIRECTOR <u>James McLaughlin</u>			ADDRESS <u>Marceline, Mo</u>		25. DATE RECD. BY LOCAL REG. <u>2-9-1960</u>		26. REGISTRAR'S SIGNATURE <u>Broovie Owens</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 Gerald I Wade

Licensed Embalmer No. 4172

P. O. Address Brown

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.