

# RI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

**-60-007184**

FILED VS MAR 4 1960 187

Registration District No. 187 Primary Registration District No. 8440 Registrar's No. 38

STATE FILE NUMBER

IDED

<b>1. PLACE OF DEATH</b> a. COUNTY <u>Livingston</u>				<b>2. USUAL RESIDENCE</b> (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Linn</u>				
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Chillicothe</u>		Length of stay in 1b <u>3 yrs.</u>		c. CITY OR TOWN <u>New Boston,</u>		Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>		
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>Millers Rest Home</u>			Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location) <u>RFD # 1</u>		Reside on Farm Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
<b>3. NAME OF DECEASED</b> (Type or print) First Middle Last <u>Elwood E. Thudium</u>				<b>4. DATE OF DEATH</b> Month Day Year <u>Feb. 26. 1960</u>				
<b>5. SEX</b> <u>M</u>	<b>6. COLOR OR RACE</b> <u>W</u>	<b>7. Married</b> <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>		<b>8. DATE OF BIRTH</b> <u>Sept. 2, 1876</u>	<b>9. AGE (last birthday)</b> <u>83</u>	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HR Hours Min.	
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>Farmer, ret.</u>		<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <u>Own farm</u>		<b>11. BIRTHPLACE</b> (City and state or country) <u>New Boston, Mo.</u>		<b>12. CITIZEN OF WHAT COUNTRY</b> <u>U. S.</u>		
<b>13a. FATHER'S NAME</b> <u>Henry Thudium</u>			<b>13b. MOTHER'S MAIDEN NAME</b> <u>Laura McCollum</u>		<b>14. NAME OF HUSBAND OR WIFE</b> <u>Mellie E. Jones</u>			
<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>		<b>16. SOCIAL SECURITY NO.</b> <u>None</u>		<b>17. INFORMANT</b> Address <u>17 Clay St.</u> <u>Mrs. Hubert Baskett Chillicothe, Mo.</u>				
<b>18. CAUSE OF DEATH</b> (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Hemorrhage</u> DUE TO (b) <u>Arteriosclerosis</u> DUE TO (c) _____ Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.						INTERVAL BETWEEN ONSET AND DEATH <u>3 days</u>		
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		
<b>19. WAS AUTOPSY PERFORMED?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	<b>20a. ACCIDENT</b> <input type="checkbox"/>	<b>SUICIDE</b> <input type="checkbox"/>	<b>HOMICIDE</b> <input type="checkbox"/>	<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in PART I or PART II of item 18.)				
<b>20c. TIME OF INJURY</b> Hour a.m. p.m.	Month, Day, Year							
<b>20d. INJURY OCCURRED WHILE AT WORK</b> <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		<b>20e. PLACE OF INJURY</b> (e.g., in or about home, farm, factory, street, office bldg., etc.)		<b>20f. CITY, TOWN, OR LOCATION</b>		COUNTY STATE		
<b>21.</b> I attended the deceased from <u>Oct 11-1958</u> to <u>Feb 26-60</u> and last saw him alive on <u>Feb 26-60</u> Death occurred at <u>3:15 p</u> m on the date stated above, and to the best of my knowledge, from the causes stated.								
<b>22a. SIGNATURE</b> (Degree or title) <u>W. Baskett D.O.</u>				<b>22b. ADDRESS</b> <u>Chillicothe</u>		<b>22c. DATE SIGNED</b> <u>2/27/60</u>		
<b>23a. BURIAL, CREMATION, REMOVAL</b> (Specify) <u>Burial</u>	<b>23b. DATE</b> <u>Feb. 28, 1960</u>	<b>23c. NAME OF CEMETERY OR CREMATORY</b> <u>Rose Hill Cemetery</u>		<b>23d. LOCATION</b> (City, town, or county) <u>Brookfield, Mo.</u>			(State)	
<b>24. FUNERAL DIRECTOR</b> ADDRESS <u>Wright Funeral Home, Brookfield, Mo.</u>				<b>25. DATE RECD. BY LOCAL REG.</b> <u>2/27/60</u>		<b>26. REGISTRAR'S SIGNATURE</b> <u>Frances B Neale</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 Harold B. Wright

Licensed Embalmer No. 3718

P. O. Address Brookfield, Mo.

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.