

1 DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

FILED VS MAR 15 1960

290

-60-007650
STATE FILE NUMBER

Registration District No. _____ Primary Registration District No. _____ Registrar's No. 26

| | | | | | | | | |
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| 1. PLACE OF DEATH a. COUNTY <u>Pulaski Co</u> | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> COUNTY <u>Pulaski Co</u> | | | | |
| b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Waynesville, Mo.</u> | | Length of stay in 1b <u>1/2 hr.</u> | | c. CITY OR TOWN <u>Crocker, Missouri</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>Way. Gen. Hospital.</u> | | | Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/> | | d. STREET ADDRESS (If outside, give location) <u>Rural Rt. # 3</u> | | Reside on Farm Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) First <u>Della</u> Middle <u>Ethel.</u> Last <u>Long.</u> | | | | 4. DATE OF DEATH Month <u>Feb.</u> Day <u>26,</u> Year <u>1960</u> | | | | |
| 5. SEX <u>Female</u> | 6. COLOR OR RACE <u>White.</u> | 7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/> | | 8. DATE OF BIRTH <u>10/9/1877</u> | 9. AGE (last birthday) <u>72 yrs.</u> | 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) <u>House wife.</u> | | | 10b. KIND OF BUSINESS OR INDUSTRY ----- | | 11. BIRTHPLACE (City and state or country) <u>Missouri</u> | | 12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u> | |
| 13a. FATHER'S NAME <u>John Gibson</u> | | | 13b. MOTHER'S MAIDEN NAME <u>Angeline. Unknown.</u> | | | 14. NAME OF HUSBAND OR WIFE <u>George Wilson Long.</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>None.</u> | | 17. INFORMANT Address <u>Mrs. Marie Ashmore. Crocker, Mo</u> | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: | | | | | | | INTERVAL BETWEEN ONSET AND DEATH | |
| IMMEDIATE CAUSE (a) <u>Bronchial Pneumonia</u> | | | | | | | <u>3 days</u> | |
| DUE TO (b) <u>Cerebral Hemorrhage</u> | | | | | | | <u>4 WKS</u> | |
| DUE TO (c) <u>Essential Hypertension</u> | | | | | | | <u>10 YRS</u> | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>Diabetes Mellitus</u> | | | | | | | 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 _____ 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.) <u>✓</u> | | 20f. CITY, TOWN, OR LOCATION <u>✓</u> | | COUNTY _____ STATE _____ | | |
| 21. I attended the deceased from <u>1945</u> to <u>Feb 26, 1960</u> and last saw ^{her} _{him} alive on <u>Feb 26, 1960</u> Death occurred at <u>3:00</u> P.m. on the date stated above, and to the best of my knowledge, from the causes stated. | | | | | | | | |
| 22a. SIGNATURE <u>John A. Mikalovich</u> (Degree or title) <u>D.O.</u> | | | | 22b. ADDRESS <u>Crocker, Missouri</u> | | | 22c. DATE SIGNED <u>2/27/60</u> | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | | 23b. DATE <u>2/29/60</u> | 23c. NAME OF CEMETERY OR CREMATORY <u>Crocker Memorial Cemetery</u> | | 23d. LOCATION (City, town, or county) <u>Crocker, Mo</u> | | (State) _____ | |
| 24. FUNERAL HOME ADDRESS <u>Healy's Funeral Home Crocker, Mo</u> | | | | 25. DATE RECD. BY LOCAL REG. <u>2-29-60</u> | | 26. REGISTRAR'S SIGNATURE <u>Paul A. Anderson</u> | | |

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

MS MAR 15 1960

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 Clarence Thross

Licensed Embalmer No. 4896

P. O. Address Waynesville

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.