

**FRI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH**

**-60-007754**

**FILED VS FEB 17 1960**

Registration District No. 01 Primary Registration District No. \_\_\_\_\_ Registrar's No. 16

STATE FILE NUMBER

|   |  |   |   |
|---|--|---|---|
| 1. PLACE OF DEATH<br>a. COUNTY <u>Ripley.</u>   |  | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <u>Missouri.</u> b. COUNTY <u>Ripley.</u> |   |
| b. CITY (if outside corporate limits, give TOWNSHIP only)<br>OR TOWN <u>Doniphan.</u>                       | Length of stay in 1b<br><u>4 months.</u>   | c. CITY OR TOWN <u>Doniphan.</u>  | Inside Limits<br>Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>  |
| c. FULL NAME OF (if NOT in hospital, give location)<br>HOSPITAL OR INSTITUTION <u>905 E. Locust Street.</u> | Inside Limits<br>Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> | d. STREET ADDRESS (if outside, give location)<br><u>905 E. Locust Street.</u>   | Reside on Farm<br>Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> |

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| 3. NAME OF DECEASED (Type or print)<br>First <u>Boyd</u> Middle <u>Mitchell</u> Last <u>Whitwell.</u> | 4. DATE OF DEATH<br>Month <u>January</u> Day <u>27</u> Year <u>1960.</u> |
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|                     |                                |   |                                       |                                   |  |  |
|---------------------|--------------------------------|---|---------------------------------------|-----------------------------------|--|--|
| 5. SEX <u>Male.</u> | 6. COLOR OR RACE <u>White.</u> | 7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/><br>Widowed <input type="checkbox"/> Divorced <input type="checkbox"/> | 8. DATE OF BIRTH <u>Feb. 1, 1894.</u> | 9. AGE (last birthday) <u>65.</u> | IF UNDER 1 YEAR<br>Months _____ Days _____ | IF UNDER 24 HR<br>Hours _____ Min. _____ |
|---------------------|--------------------------------|---|---------------------------------------|-----------------------------------|--|--|

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| 10a. USUAL OCCUPATION (Give kind of work done<br>work <del>throughout</del> of working life, even if retired)<br><u>Naval Ammunition Depot.</u> | 10b. KIND OF BUSINESS OR INDUSTRY<br><u>Civil Service.</u> | 11. BIRTHPLACE (City and state or country)<br><u>Bennett, Missouri.</u> | 12. CITIZEN OF WHAT COUNTRY<br><u>USA.</u> |
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| 13a. FATHER'S NAME<br><u>Samuel Pope Whitwell.</u> | 13b. MOTHER'S MAIDEN NAME<br><u>Josephine Horner.</u> | 14. NAME OF HUSBAND OR WIFE<br><u>Hattie Whitwell.</u> |
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| 15. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(Yes, no, or unknown) (If yes, give war or dates of service)<br><u>Yes. W. W. I.</u> | 16. SOCIAL SECURITY NO.<br><u>492-24-8191.</u> | 17. INFORMANT<br><u>Hattie Whitwell, Doniphan, Missouri.</u> | Address |
|---|--|--|---------|

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| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:.. |   | INTERVAL BETWEEN ONSET AND DEATH |
| IMMEDIATE CAUSE (a)  | <u>Coronary Thrombosis.</u>                   | <u>one hr.</u>                   |
| Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.                 | DUE TO (b) <u>Cerebral Arterio Sclerosis.</u> | <u>?</u>                         |
|  | DUE TO (c) <u>General Arterio Sclerosis.</u>  | <u>?</u>                         |

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| 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.<br><input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown |
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| 19. WAS AUTOPSY PERFORMED?<br>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.) |
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|   |   |  |                              |        |       |
|---|---|--|------------------------------|--------|-------|
| 20c. TIME OF INJURY<br>Hour _____<br>a.m. _____<br>p.m. _____ | 20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/><br>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 |
|---|---|--|------------------------------|--------|-------|

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| 21. I attended the deceased from <u>Jan 26-1960</u> to <u>Jan 27-60</u> and last saw <sup>her</sup> him alive on <u>Jan 27-60.</u><br>Death occurred at <u>12:45 a.m.</u> m on the date stated above, and to the best of my knowledge, from the causes stated. |
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| 22a. SIGNATURE<br><u>R. Boorn, M.D.</u> (Degree or title) | 22b. ADDRESS<br><u>903 Elm Doniphan, Missouri.</u> | 22c. DATE SIGNED<br><u>2-2-60.</u> |
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| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><u>Burial.</u> | 23b. DATE<br><u>Jan 30, 1960</u> | 23c. NAME OF CEMETERY OR CREMATORY<br><u>Doniphan Cemetery.</u> | 23d. LOCATION (City, town, or county)<br><u>Doniphan, Missouri.</u> | (State) |
|---|----------------------------------|---|---|---------|

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| 24. FUNERAL DIRECTOR<br><u>Ray Means, Doniphan, Missouri.</u> | ADDRESS | 25. DATE RECD. BY LOCAL REG.<br><u>2-12-60</u> | 26. REGISTRAR'S SIGNATURE<br><u>Flava Broz</u> |
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DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

VS FEB 20 1960

APR 15 1960

APR 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 Ray Measor

Licensed Embalmer No. 3743

P. O. Address Doniphan

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.