

URI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-60-009525

FILED VS. MAR 15 1960 337 Registration District No. Primary Registration District No. Registrar's No. 18

STATE FILE NUMBER

ENDED

1. PLACE OF DEATH a. COUNTY <b>Shelby.</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Missouri</b> b. COUNTY <b>Randolph</b>							
b. CITY (If outside corporate limits, give TOWNSHIP only) <b>Lentner Mo</b>		Length of stay in 1b		c. CITY OR TOWN <b>Moberly Mo</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>					
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION			Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location) <b>524 Roberts St</b>			Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <b>Ola May Wright</b>				4. DATE OF DEATH <b>March 3 1960</b>		Month		Day		Year	
5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>		7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input checked="" type="checkbox"/>		8. DATE OF BIRTH <b>7/13/ 1925</b>		9. AGE (last birthday) <b>34</b>		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>House Wife</b>			10b. KIND OF BUSINESS OR INDUSTRY <b>Own Home</b>		11. BIRTHPLACE (City and state or country) <b>Kansas</b>		12. CITIZEN OF WHAT COUNTRY <b>U.S.A.</b>				
13a. FATHER'S NAME <b>Romie Thornhill</b>				13b. MOTHER'S MAIDEN NAME <b>Charles Yengling</b>				14. NAME OF HUSBAND OR WIFE <b>Dovoreed</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <b>486-26-3385</b>		17. INFORMANT Address <b>Romie Thornhill Higbee Mo</b>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Fracture of Frontal, Parietal, Occipital.</b> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <b>Due to Truck Train collision</b> DUE TO (c)										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) <b>Train hit Milk truck.</b>										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 checked="" 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.) <b>Same as above</b>							
20c. TIME OF INJURY <b>12:00 a.m.</b>		Hour Month, Day, Year <b>3 3 60</b>		20d. INJURY OCCURRED WHILE AT WORK <input checked="" 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.) <b>Street</b>		20f. CITY, TOWN, OR LOCATION <b>Lentner</b>		COUNTY STATE <b>Shelby Mo</b>	
21. I attended the deceased from _____, to _____ and last saw her/him alive on _____ Death occurred at _____ m on the date stated above, and to the best of my knowledge, from the causes stated.											
22a. SIGNATURE (Degree or title) <i>[Signature]</i> <b>Coroner</b>						22b. ADDRESS <b>Bethel, Missouri</b>			22c. DATE SIGNED <b>3/8/60</b>		
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE <b>March 5 1960</b>		23c. NAME OF CEMETERY OR CREMATORY <b>City</b>		23d. LOCATION (City, town, or county) <b>Higbee Mo</b>		(State)			
24. FUNERAL DIRECTOR <b>Burton Funeral Home Higbee Mo</b>				ADDRESS		25. DATE RECD. BY LOCAL REG. <b>Mar 11-1960</b>		26. REGISTRAR'S SIGNATURE <i>[Signature]</i>			

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

MS APR 5 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 me  
or by \_\_\_\_\_, Student Embalmer No. \_\_\_\_\_  
working under my personal supervision.

Student \_\_\_\_\_  
Signature of Student Embalmer

Signed Paul E. Hayes

Licensed Embalmer No. 4461

P. O. Address Stellbina

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.