

JURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-60-009554

STATE FILE NUMBER

DR MAGNUS

Registration District No.

352

Primary Registration District No.

Registrar's No.

19

ENDED

FILED VS MAR 9 1960

1. PLACE OF DEATH a. COUNTY <b>Taney</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Missouri</b> COUNTY <b>Taney</b>									
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>Branson</b>		Length of stay in 1b <b>2 Months</b>		c. CITY OR TOWN <b>Hollister</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 <b>Skaggs Hosp.</b>			Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location) <b>Hollister</b>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>						
3. NAME OF DECEASED (Type or print) First Middle Last <b>OVIE E. ALLEN</b>				4. DATE OF DEATH Month Day Year <b>Mar. 2, 1960</b>									
5. SEX <b>female</b>		6. COLOR OR RACE <b>white</b>		7. Married <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>		8. DATE OF BIRTH <b>12-8-1874</b>		9. AGE (last birthday) <b>85</b>		IF UNDER 1 YEAR Months <b>2</b> Days <b>24</b>		IF UNDER 24 HR Hours <b></b> Min. <b></b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>retired</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>housekeeper</b>		11. BIRTHPLACE (City and state or country) <b>Tenn.</b>		12. CITIZEN OF WHAT COUNTRY <b>USA</b>					
13a. FATHER'S NAME <b>William Allen</b>				13b. MOTHER'S MAIDEN NAME <b>Nancy Norris</b>				14. NAME OF HUSBAND OR WIFE <b>none</b>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>no</b>				16. SOCIAL SECURITY NO. <b>none</b>		17. INFORMANT Address <b>Mrs Ora Holland Hollister, 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>Cerebral Vascular Accident</b>										INTERVAL BETWEEN ONSET AND DEATH <b>4 days</b>			
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <b>arteriosclerotic Heart disease</b>										<b>20 yrs</b>			
DUE TO (c) <b>Generalized arteriosclerosis</b>										<b>30 yrs</b>			
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 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 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 <b>July 19 52</b> to <b>2 March 60</b> and last saw her <sup>her</sup> alive on <b>2/27/60</b> Death occurred at <b>12 02 AM</b> on the date stated above, and to the best of my knowledge, from the causes stated.													
22a. SIGNATURE <b>W C Magnus, M.D.</b>						22b. ADDRESS <b>Branson, Mo</b>			22c. DATE SIGNED <b>3/3/60</b>				
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>burial</b>		23b. DATE <b>3-6-60</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Cedar Valley Cem.</b>		23d. LOCATION (City, town, or county) <b>Hollister, Mo</b>							
24. FUNERAL DIRECTOR <b>Whelchel Chapel Branson, Mo</b>				25. DATE RECD. BY LOCAL REG. <b>3/5/60</b>		26. REGISTRAR'S SIGNATURE <b>Rebecca Campbell</b>							

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 Walter Cobb

Licensed Embalmer No. 4731

P. O. Address Brown

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.