

DEPARTMENT OF HEALTH - STANDARD CERTIFICATE OF DEATH

60-009752

FILED VS APR 14 1960

Registration District No. 4 Primary Registration District No. 4014 Registrar's No. 160

STATE FILE NUMBER

1. PLACE OF DEATH a. COUNTY ATCHISON				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MISSOURI b. COUNTY HOLT									
b. CITY (If outside corporate limits, give TOWNSHIP only) FAIRFAX		Length of stay in lb 12 Days		c. CITY OR TOWN MOUND City		Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>							
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Community Hosp.			Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location) 2 miles EAST		Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>						
3. NAME OF DECEASED (Type or print) First Middle Last PETER KEITH DILTS				4. DATE OF DEATH Month Day Year MARCH 30, 1960									
5. SEX MALE		6. COLOR OR RACE WHITE		7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>		8. DATE OF BIRTH 12/13/1888		9. AGE (last birthday) 71		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) FARMER				10b. KIND OF BUSINESS OR INDUSTRY FARMING		11. BIRTHPLACE (City and state or country) Nodaway Co. Mo.		12. CITIZEN OF WHAT COUNTRY U.S.A.					
13a. FATHER'S NAME ELDRIDGE DILTS				13b. MOTHER'S MAIDEN NAME JULIA RIGGLE				14. NAME OF HUSBAND OR WIFE PEARL DILTS					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No				16. SOCIAL SECURITY NO. 496-07-0746		17. INFORMANT Address MRS. RUBY ELDER- MOUND City, Mo.							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial infarction, acute										INTERVAL BETWEEN ONSET AND DEATH 14 days			
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) Coronary artery atherosclerosis										14 days			
DUE TO (c) Coronary arteriosclerosis										15 yrs			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) Obesity; Fatty infiltration of liver due to alcohol abuse; Hydrophobia, etc.										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 checked="" type="checkbox"/> NO <input type="checkbox"/>		20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury if 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.)		20f. CITY, TOWN, OR LOCATION		COUNTY		STATE			
21. I attended the deceased from _____, to _____ and last saw her/him alive on _____ Death occurred at _____ on the date stated above, and to the best of my knowledge, from the causes stated.													
22a. SIGNATURE (Degree or title) B. G. Suttle M.D. Pathologist				22b. ADDRESS Fairfax Comm. Hosp. Fairfax Mo.				22c. DATE SIGNED 3-30-60					
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE 4-2-1960		23c. NAME OF CEMETERY OR CREMATORY MOUNT HOPE				23d. LOCATION (City, town, or county) (State) MOUND City, Mo.					
24. FUNERAL DIRECTOR James H. Crawford, Mound City, Mo.				25. DATE RECD. BY LOCAL REG. April 4, 1960		26. REGISTRAR'S SIGNATURE Tharvin J. Schaefer							

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

APR 17 1956

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 James Crawford

Licensed Embalmer No. 4796

P. O. Address Mound Ce

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.