

JRI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

60-009853

FILED VS APR 4 1960

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Registration District No. _____ Primary Registration District No. 3006 Registrar's No. 198

STATE FILE NUMBER

1. PLACE OF DEATH a. COUNTY <u>Boone</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE, <u>MO.</u> b. COUNTY <u>Randolph</u>					
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Columbia</u>		Length of stay in 1b		c. CITY OR TOWN <u>Higby Higbee</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>			
c. FULL NAME OF (IF NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>UNIVERSITY OF MO. MEDICAL CENTER</u>			Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location)		Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First <u>FRATIC</u> Middle <u>Lessley</u> Last <u>Adams</u>				4. DATE OF DEATH Month <u>3</u> - Day <u>30</u> - Year <u>60</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>1-14-77</u>	9. AGE (last birthday) <u>83</u>	IF UNDER 1 YEAR Months _____ Days _____ Hours _____ Min. _____	IF UNDER 24 HR Hours _____ Min. _____		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (City and state or country) <u>Higby, Mo.</u>		12. CITIZEN OF WHAT COUNTRY <u>U.S.</u>		
13a. FATHER'S NAME <u>Joseph Lessley</u>			13b. MOTHER'S MAIDEN NAME <u>M. Johnson</u>			14. NAME OF HUSBAND OR WIFE			
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.		17. INFORMANT Address <u>University of Mo. Medical Records</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>Hypoxia</u>									
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <u>Aspiration of foreign material.</u>									
DUE TO (c) <u>Emesis.</u>									
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>obstructive jaundice</u> <u>Carcinoma of pancreas, hepatic insufficiency, metabolic acidosis</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 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 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.)		20f. CITY, TOWN, OR LOCATION		COUNTY		STATE	
21. I attended the deceased from <u>3-1-60</u> to <u>3-30-60</u> and last saw her alive on <u>3-29-60</u> Death occurred at <u>6:10 AM</u> <u>3-30-60</u> m on the date stated above, and to the best of my knowledge, from the causes stated.									
22a. SIGNATURE (Degree or title) <u>John H. Logan M.D.</u>				22b. ADDRESS <u>114 Mo Med Center</u>				22c. DATE SIGNED <u>3/30</u>	
23a. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE <u>April 1960</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Higby Cem</u>		23d. LOCATION (City, town, or county) (State) <u>Higbee Mo</u>				
24. FUNERAL DIRECTOR <u>Million Funeral Home Moberly, Mo</u>			25. DATE RECD. BY LOCAL REG. <u>Mar 30 1960</u>		26. REGISTRAR'S SIGNATURE <u>Mrs R.E. Palmer</u>				

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

APR 18 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 Marian E. Million

Licensed Embalmer No. 395

P. O. Address Maherly

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.