

JRI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

60-010415

FILED VS. MAR 21 1960

Registration District No. 100 Primary Registration District No. 3018 Registrar's No. 26

STATE FILE NUMBER

ENDED

1. PLACE OF DEATH a. COUNTY <u>DENT</u> b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>SALEM</u> Length of stay in 1b <u>10 DAYS</u> c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>HART CLINIC</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MISSOURI</u> b. COUNTY <u>CRAWFORD</u> c. CITY OR TOWN <u>DILLARD</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 checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>ADIE</u> Middle <u>-</u> Last <u>MINCHER</u>			4. DATE OF DEATH Month <u>MARCH</u> Day <u>14</u> Year <u>1960</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>1-22-1877</u>	9. AGE (last birthday) <u>83</u>	IF UNDER 1 YEAR Months _____ Days _____ 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 <u>-</u>		11. BIRTHPLACE (City and state or country) <u>DILLARD, Mo.</u>			
12. CITIZEN OF WHAT COUNTRY <u>USA</u>		13a. FATHER'S NAME <u>JACK TINKER</u>		13b. MOTHER'S MAIDEN NAME <u>REBECCA CAPPS</u>			
14. NAME OF HUSBAND OR WIFE <u>JOHN T. MINCHER</u>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>NONE</u>			
17. INFORMANT <u>RAY MINCHER - HUZZAH, Mo.</u>		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Arteriosclerotic heart disease</u> DUE TO (b) _____ DUE TO (c) _____ Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.		INTERVAL BETWEEN ONSET AND DEATH <u>10 yrs.</u>			
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 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 _____		20g. COUNTY _____		20h. STATE _____			
21. I attended the deceased from <u>3/22/48</u> and last saw her <u>3/14/60</u> alive on <u>3/14/60</u> Death occurred at <u>8:40 p.m.</u> on the date stated above, and to the best of my knowledge, from the causes stated.							
22a. SIGNATURE <u>[Signature]</u> (Deceased or title)			22b. ADDRESS <u>SALEM, Mo.</u>		22c. DATE SIGNED <u>3/17/60</u>		
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE <u>3-17-1960</u>	23c. NAME OF CEMETERY OR CREMATORY <u>VIBURNUM CEMETERY</u>		23d. LOCATION (City, town, or county) (State) <u>VIUBURNUM, MISSOURI</u>		
24. FUNERAL DIRECTOR <u>Thomas S. Hallock - STEELVILLE, Mo.</u> ADDRESS _____			25. DATE RECD. BY LOCAL REG. <u>3/17/60</u>		26. REGISTRAR'S SIGNATURE <u>M.M. Hart, M.D.</u>		

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 Carl R. Spencer

Licensed Embalmer No. 237

P. O. Address Salem

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to do 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.