

JRI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

60-010736

FILED VS APR 11 1960

Registration District No. 141 Primary Registration District No. 3025 Registrar's No. 60

STATE FILE NUMBER

1. PLACE OF DEATH a. COUNTY <u>Howell</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Howell</u>					
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>West Plains</u>		Length of stay in 1b <u>3 hrs</u>		c. CITY OR TOWN <u>West Plains</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>West Plains Memorial</u>			Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location) <u>1017 Lincoln</u>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First <u>Teresa</u> Middle <u>Lynne</u> Last <u>McGownd</u>				4. DATE OF DEATH Month <u>April</u> Day <u>3</u> Year <u>1960</u>					
5. SEX <u>Female</u>	6. COLOR OR RACE <u>Cau</u>	7. Married <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>		8. DATE OF BIRTH <u>4-2-1960</u>	9. AGE (last birthday) <u>--</u>		IF UNDER 1 YEAR Months <u>--</u> Days <u>--</u>	IF UNDER 24 HR Hours <u>3</u> Min. <u>15</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)			10b. KIND OF BUSINESS OR INDUSTRY <u>-----</u>		11. BIRTHPLACE (City and state or country) <u>West Plains, Mo.</u>		12. CITIZEN OF WHAT COUNTRY <u>USA</u>		
13a. FATHER'S NAME <u>Raymond McGownd</u>			13b. MOTHER'S MAIDEN NAME <u>Gladys (McCallister) McGownd</u>			14. NAME OF HUSBAND OR WIFE <u>-----</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>			16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT Address <u>Raymond McGownd West Plains, Missouri</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>BIRTH INJURY</u> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. <u>OCCIPUT POSTERIOR POSITION</u> DUE TO (b) <u>-----</u> DUE TO (c) <u>-----</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>-----</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							INTERVAL BETWEEN ONSET AND DEATH <u>6 HOURS</u>		
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.) <u>-----</u>					
20c. TIME OF INJURY Hour <u>-----</u> Month, Day, Year <u>-----</u> a.m. <u>-----</u> p.m. <u>-----</u>		20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <u>-----</u>		20f. CITY, TOWN, OR LOCATION <u>-----</u>		COUNTY <u>-----</u>		STATE <u>-----</u>
21. I attended the deceased from <u>4-2-60</u> to <u>4-3-60</u> and last saw her alive on <u>4-3-60</u> Death occurred at <u>1:45 PM</u> on the date stated above, and to the best of my knowledge, from the causes stated.									
22a. SIGNATURE <u>Jack H. Wiles</u> (Degree or Title)				22b. ADDRESS <u>West Plains, Mo</u>				22c. DATE SIGNED <u>4-6-60</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE <u>4-4-60</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Lone Star Cemetery</u>		23d. LOCATION (City, town, or county)* <u>Wtn Grove, Missouri</u> (State)				
24. FUNERAL DIRECTOR <u>Howell C. Craig Wtn Grove Missouri</u>				25. DATE RECD. BY LOCAL REG. <u>4-9-1966</u>		26. REGISTRAR'S SIGNATURE <u>Beatrice Cook</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 *Arnold C. Craig*

Licensed Embalmer No. 4769

P. O. Address *Mt. Hope*

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