

R DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

60-010753

FILED VS MAR 28 1960

STATE FILE NUMBER

Registration District No. 141 Primary Registration District No. 5551 Registrar's No. 50

1. PLACE OF DEATH a. COUNTY <u>Newell</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Mo</u> b. COUNTY <u>Newell</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>West Plains</u>	Length of stay in 1b. <u>78 yrs</u>	c. CITY OR TOWN <u>West Plains</u>	Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
c. FULL NAME OF HOSPITAL OR INSTITUTION <u>Lebo Rte</u>	Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	d. STREET ADDRESS (If outside give location) <u>Lebo Rte</u>	Reside on Farm Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>

3. NAME OF DECEASED (Type or print) First Middle Last <u>Wester Mae Penn</u>			4. DATE OF DEATH Month Day Year <u>3-9-1960</u>		
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5. SEX <u>♀</u>	6. COLOR OR RACE <u>W</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>10-9-81</u>	9. AGE (last birthday) <u>78</u>	IF UNDER 1 YEAR Months Days	IF UNDER 24 HR Hours Min.
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>News</u>	10b. KIND OF BUSINESS OR INDUSTRY <input checked="" type="checkbox"/>	11. BIRTHPLACE (City and state or country) <u>West Plains Mo</u>	12. CITIZEN OF WHAT COUNTRY <u>USA</u>
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13a. FATHER'S NAME <u>J. Richardson</u>	13b. MOTHER'S MAIDEN NAME <u>Melba Bailey</u>	14. NAME OF HUSBAND OR WIFE <input checked="" type="checkbox"/>
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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. <u>J.P. Penn, West Plains Mo</u>
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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>Cerebral Hemorrhage</u>		INTERVAL BETWEEN ONSET AND DEATH <u>10 minutes</u>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) <u>Cerebral Arteriosclerosis</u>	
	DUE TO (c)	

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>Chronic Cerebral Hemorrhage & Senility</u>	PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown
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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.)
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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
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21. I attended the deceased from 11:30 P. to 3-9-60 and last saw her alive on 1-13-60
Death occurred at _____ m on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE <u>Jack Wiles, M.D.</u>	22b. ADDRESS <u>West Plains, Mo.</u>	22c. DATE SIGNED <u>3-22-60</u>
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23a. BURIAL OR CREATION, REMOVAL (Specify)	23b. DATE <u>3-12-60</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Oak Lawn</u>	23d. LOCATION (City, town, or county) (State) <u>West Plains Mo</u>
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24. FUNERAL DIRECTOR <u>Robertson, West Plains Mo</u>	25. DATE RECD. BY LOCAL REG. <u>3-25-60</u>	26. REGISTRAR'S SIGNATURE <u>Beatrice Cook</u>
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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 *D. A. Roberts*

Licensed Embalmer No. 347
P. O. Address *West*

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