

FEDERAL DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

60-011482

FILED VS APR 12 1960

Registration District No. 156 Primary Registration District No. 2001 Registrar's No. 162 STATE FILE NUMBER

1. PLACE OF DEATH a. COUNTY <u>Jasper</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>McDONALD</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Joplin</u>		Length of stay in 1b <u>2 weeks</u>	c. CITY OR TOWN <u>Goodman</u> Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>Freeman Hospital</u>		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <u>Route 1</u> Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>

3. NAME OF DECEASED (Type or print) First <u>WANDA</u> Middle <u>Lee</u> Last <u>Giffey</u>			4. DATE OF DEATH Month <u>Feb</u> Day <u>20</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 type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <u>3-22-1941</u>	9. AGE (last birthday) <u>18</u>	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) <u>None</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>		11. BIRTHPLACE (City and state or country) <u>Springfield, Mo.</u>		12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>
13a. FATHER'S NAME <u>Giffey</u>		13b. MOTHER'S MAIDEN NAME <u>Wanetta Hight</u>		14. NAME OF HUSBAND OR WIFE <u>None</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.		17. INFORMANT <u>Marion Holloway Goodman, Mo.</u> Address _____		

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) Extensive malignant ulcerative colitis INTERVAL BETWEEN ONSET AND DEATH 1 year

Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) _____
DUE TO (c) _____

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.
 Yes No Unknown

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.)	
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 6-27-58 to 2-20-60 and last saw her ^{her} alive on 2-20-60
Death occurred at 8:10 A m on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE <u>B. E. Dotson Sr., M.D.</u> (Doctor or title)	22b. ADDRESS <u>410 Jackson, Joplin, Mo.</u>	22c. DATE SIGNED <u>4-4-60</u>
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23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE <u>Feb 22, 1960</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Memorial Garden</u>	23d. LOCATION (City, town, or county) (State) <u>Neosho Missouri</u>
24. FUNERAL DIRECTOR <u>Roller Funeral Home</u> <u>Anderson, Mo.</u>	25. DATE RECD. BY LOCAL REG. <u>4-6-1960</u>	26. REGISTRAR'S SIGNATURE <u>Sove Merriam</u>	

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

AUG 3 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 Robert C. Poller

Licensed Embalmer No. 5062

P. O. Address Andover, M

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.