

IRI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

60-011826

FILED VS MAR 30 1960

Registration District No. 209 Primary Registration District No. Registrar's No. 20 STATE FILE NUMBER

1. PLACE OF DEATH a. COUNTY <b>MARION</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MISSOURI</b> b. COUNTY <b>MONROE</b>					
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>WARREN TOWNSHIP</b>		Length of stay in 1b		c. CITY OR TOWN <b>MONROE CITY</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>			
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>MONROE CITY</b>			Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>		d. STREET ADDRESS (If outside, give location) <b>600 N. LOCUST ST</b>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First <b>CHARLES</b> Middle <b>AUGUSTINE</b> Last <b>Mc CLINTIC</b>				4. DATE OF DEATH Month <b>MARCH</b> Day <b>9</b> Year <b>1960</b>					
5. SEX <b>MALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>		8. DATE OF BIRTH <b>3-9-1892</b>	9. AGE (last birthday) <b>68</b>	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) <b>FARMER</b>			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (City and state or country) <b>MARION COUNTY, MO</b>		12. CITIZEN OF WHAT COUNTRY <b>U. S. A.</b>		
13a. FATHER'S NAME <b>JAMES Mc CLINTIC</b>			13b. MOTHER'S MAIDEN NAME <b>LAVENIA YANCEY</b>			14. NAME OF HUSBAND OR WIFE <b>PAULYNE Mc CLINTIC</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>NO</b>			16. SOCIAL SECURITY NO. <b>489-10-9789</b>		17. INFORMANT <i>Blair Mc Clintic Shattille Mo</i>				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary Occlusion</b>							INTERVAL BETWEEN ONSET AND DEATH <b>1-2 hrs</b>		
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <b>Coronary sclerosis</b>							unknown		
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. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> 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 checked="" 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 _____, to _____ and last saw her/him alive on _____. Death occurred at <b>4 P.M.</b> on the date stated above, and to the best of my knowledge, from the causes stated.									
22a. SIGNATURE (Degree or title) <i>Henry W Sweet Jr MD-Coroner</i>				22b. ADDRESS <i>1 Hannibal Mo</i>			22c. DATE SIGNED <b>3/17/60</b>		
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		23b. DATE <b>3-11-60</b>	23c. NAME OF CEMETERY OR CREMATORY <b>St JUDES CEMETERY</b>		23d. LOCATION (City, town, or county) (State) <b>MONROE CITY, MO</b>				
24. FUNERAL DIRECTOR <i>Wilson's Son</i>			ADDRESS <i>Monroe City Mo</i>		25. DATE RECD. BY LOCAL REG. <b>3-18-1960</b>		26. REGISTRAR'S SIGNATURE <i>Dr. E. M. Lucke</i> <i>By Viola Gier, Deputy</i>		

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

NS MAR 30 1980

**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 mm \_\_\_\_\_, Student Embalmer No. \_\_\_\_\_

working under my personal supervision.

Student \_\_\_\_\_  
Signature of Student Embalmer

Signed Leslie L. Wilson

Licensed Embalmer No. 3014  
P. O. Address Monroe City

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.