

FRI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

FILED VS APR 5 1960

60-012713

STATE FILE NUMBER

Registration District No. _____ Primary Registration District No. _____ Registrar's No. **2 3209**

1. PLACE OF DEATH a. COUNTY <u>ST. LOUIS</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MISSOURI</u> b. COUNTY <u>Greene</u>									
b. CITY (If outside corporate limits, give TOWNSHIP only) <u>ST. LOUIS</u>		Length of stay in 1b <u>30 DAYS</u>		c. CITY OR TOWN <u>SPRINGFIELD</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>FRISCO HOSPITAL</u> <u>ST. LOUIS MISSOURI</u>			Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location) <u>1042 E. LOCUST</u>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>						
3. NAME OF DECEASED (Type or print) First <u>CECIL</u> Middle <u>RAY</u> Last <u>HELTON</u>				4. DATE OF DEATH Month <u>MARCH</u> Day <u>18</u> Year <u>1960</u>									
5. SEX <u>MALE</u>		6. COLOR OR RACE <u>WHITE</u>		7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>		8. DATE OF BIRTH <u>Nov. 7, 1891</u>		9. AGE (last birthday) <u>68</u>		IF UNDER 1 YEAR Months _____ Days _____ Hours _____ Min. _____		IF UNDER 24 HR Hours _____ Min. _____	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>RAILROADER</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>RAILROAD</u>				11. BIRTHPLACE (City and state or country) <u>Cherryvale, Kansas</u>		12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>			
13a. FATHER'S NAME <u>JOHN Helton</u>				13b. MOTHER'S MAIDEN NAME <u>Rebecka Haisley</u>				14. NAME OF HUSBAND OR WIFE <u>ELLA Helton</u>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>unknown</u>				16. SOCIAL SECURITY NO. <u>unknown</u>		17. INFORMANT Address <u>Ella Helton 1042 Locust, Springfield</u> 100M							
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>NO CARCINOMAS INTESTINAL</u> DUE TO (b) _____ DUE TO (c) _____ Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>METASTASES TO LIVER</u>										INTERVAL BETWEEN ONSET AND DEATH			
19. WAS AUTOPSY PERFORMED? YES <input checked="" 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		COUNTY		STATE			
21. I attended the deceased from <u>FEB 18 1960</u> to <u>MARCH 18 1960</u> and last saw him alive on <u>MARCH 18 1960</u> Death occurred at <u>5:30 PM</u> m on the date stated above, and to the best of my knowledge, from the causes stated.													
22a. SIGNATURE (Degree or title) <u>Earl Smith M.D.</u>				22b. ADDRESS <u>1695 S BRENTWOOD</u> <u>BRENTWOOD MO</u>				22c. DATE SIGNED <u>3/18/60</u>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>		23b. DATE <u>3-22-1960</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Local</u>		23d. LOCATION (City, town, or county) <u>Springfield Missouri</u>		(State)					
24. FUNERAL DIRECTOR <u>C.R. Lupton and Sons 7233 Delmar Blv'd.</u>				25. DATE RECD. BY LOCAL REG. <u>MAR 21 1960</u>		26. REGISTRAR'S SIGNATURE <u>Earl Smith, M.D.</u> <u>2118P</u>							

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF Funeral Director

0961 APR 5 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 Arnold W. Schoen

Licensed Embalmer No. 3864

P. O. Address St. Louis

No. _____ 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.