

RI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

60-013906

FILED VS MAR 16 1960

Registration District No. 356 Primary Registration District No. 4521 Registrar's No. 25

STATE FILE NUMBER

DED

1. PLACE OF DEATH a. COUNTY <u>Texas</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Mo.</u> b. COUNTY <u>Texas</u>				
b. CITY (if outside corporate limits, give TOWNSHIP only) OR TOWN <u>Houston</u>		Length of stay in 1b <u>19 days</u>		c. CITY OR TOWN <u>Clinton twp.</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>Texas County Mem. Hospital</u>			Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (if outside, give location) <u>7 mi. N/ Cabool</u>		Reside on Farm Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Benjamin</u> Middle <u>Alvin</u> Last <u>Larson</u>				4. DATE OF DEATH Month <u>3</u> Day <u>6</u> Year <u>60</u>				
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</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>9-16-1895</u>	9. AGE (last birthday) <u>64</u>	IF UNDER 1 YEAR Months <u>        </u> Days <u>        </u>	IF UNDER 24 HR Hours <u>        </u> Min. <u>        </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>engineer</u>			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (City and state or country) <u>Pine River, Miss.</u>		12. CITIZEN OF WHAT COUNTRY <u>USA</u>	
13a. FATHER'S NAME <u>unknown</u>			13b. MOTHER'S MAIDEN NAME <u>unknown</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>Yes</u> <u>World War II</u>			16. SOCIAL SECURITY NO. <u>unknown</u>		17. INFORMANT <u>Veterans Records</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) <u>Apoplexy</u>							INTERVAL BETWEEN ONSET AND DEATH <u>19 days</u>	
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. <input type="checkbox"/> Yes <input checked="" 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 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>2/16/60 12:15</u> to <u>3/6/60</u> and last saw him alive on <u>3/6/60</u> Death occurred at <u>12:15</u> <u>P</u> m on the date stated above, and to the best of my knowledge, from the causes stated.								
22a. SIGNATURE <u>Garnett Hogg</u> (Print or title)				22b. ADDRESS <u>Cabool Mo</u>			22c. DATE SIGNED <u>3/10/60</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE <u>3-9-60</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Cabool Cemetery</u>		23d. LOCATION (City, town, or county) <u>Cabool, Mo.</u>			
24. FUNERAL DIRECTOR <u>Elliott Gentry,</u> ADDRESS <u>Cabool, Mo.</u>				25. DATE RECD. BY LOCAL REG. <u>3-12-60</u>		26. REGISTRAR'S SIGNATURE <u>Myrtle Craig</u>		

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

STATEMENT BY LICENSED EMBALMER

MAR 2

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 James L. Kinty

Licensed Embalmer No. 4718

P. O. Address Calool, W

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