

R I DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

60-013907

FILED VS MAR 29 1960

STATE FILE NUMBER

Registration District No. 356 Primary Registration District No. 4521 Registrar's No. 30

1. PLACE OF DEATH a. COUNTY <u>Texas</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>California</u> b. COUNTY <u>Tulare</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Houston</u>		Length of stay in 1b <u>1 day</u>	c. CITY OR TOWN <u>Exeter</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>Texas County Memorial</u>		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <u>-----</u> Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>

3. NAME OF DECEASED (Type or print) First <u>Dottie</u> Middle <u>Faye</u> Last <u>Reser</u>			4. DATE OF DEATH Month <u>March</u> Day <u>18</u> Year <u>1960</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>Cau</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>8-4-1959</u>	9. AGE (last birthday) Months _____ Days _____ Hours _____ Min. _____	IF UNDER 1 YEAR IF UNDER 24 HR	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>-----</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>-----</u>		11. BIRTHPLACE (City and state or country) <u>Tulare, California</u>		12. CITIZEN OF WHAT COUNTRY <u>USA</u>
13a. FATHER'S NAME <u>Vernon Reser</u>		13b. MOTHER'S MAIDEN NAME <u>Lorene Hicks</u>		14. NAME OF HUSBAND OR WIFE <u>-----</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. <u>None</u>		17. INFORMANT Address <u>Lorene Hicks Reser Exeter, Calif.</u>		

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY:		INTERVAL BETWEEN ONSET AND DEATH <u>4 days</u> <u>7 mos</u>
IMMEDIATE CAUSE (a) <u>Severe Gastroenteritis</u>		
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) <u>malnutrition</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)		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.) <u>-----</u>	
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.) <u>-----</u>		20f. CITY, TOWN, OR LOCATION COUNTY STATE <u>-----</u>	
21. I attended the deceased from <u>March 17, 1960</u> to <u>March 18, 1960</u> and last saw her <u>alive</u> on <u>March 18, 1960</u> - Death occurred at <u>5:15 am</u> m on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree or title) <u>J. L. Spears M.D.</u>		22b. ADDRESS <u>Cabool, Mo.</u>	
22c. DATE SIGNED <u>3/22/60</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE <u>3-21-1960</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Lone Star Cemetery</u>	23d. LOCATION (City, town, or county) (State) <u>Mtn Grove, Missouri</u>
24. FUNERAL DIRECTOR ADDRESS <u>Ewell C. Craig Mtn. Grove, Missouri</u>		25. DATE RECD. BY LOCAL REG. <u>3-24-60</u>	26. REGISTRAR'S SIGNATURE <u>Myrtle Craig</u>

(Licensed Embalmer's Statement on Reverse Side)

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 Lowell C. Craig

Licensed Embalmer No. 4764

P. O. Address W. Groves

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.