

FRI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

60-013945

FILED VS. MAR 29 1960 360

Registration District No. \_\_\_\_\_ Primary Registration District No. 6225 Registrar's No. 75 STATE FILE NUMBER

1. PLACE OF DEATH a. COUNTY <u>Washington VERNON</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Cass</u>				
b. CITY (if outside corporate limits, give TOWNSHIP only) OR TOWN <u>Washington Township</u>		Length of stay in lb <u>15 years</u>		c. CITY OR TOWN <u>Belton</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>State Hospital #3, Nevada, Mo</u>			Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>		d. STREET ADDRESS (If outside, give location) <u>None given</u>		Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Hattie</u> Middle <u>Mc Adams</u> Last <u>Mc Adams</u>				4. DATE OF DEATH Month <u>March</u> Day <u>19</u> Year <u>1960</u>				
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>		8. DATE OF BIRTH <u>11/22/1872</u>	9. AGE (last birthday) <u>87 YRS - 4 MONTHS</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>Coffen. Ill.</u>		12. CITIZEN OF WHAT COUNTRY <u>U.S.</u>	
13a. FATHER'S NAME <u>Alex Jones</u>			13b. MOTHER'S MAIDEN NAME <u>Chathrine Thacker</u>			14. NAME OF HUSBAND OR WIFE <u>Not stated in Records</u>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>unk</u>			16. SOCIAL SECURITY NO. <u>UNK</u>		17. INFORMANT Address <u>Record State Hospital #3, Nevada, Mo</u>			
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>Coronary Heart Disease</u>							INTERVAL BETWEEN ONSET AND DEATH <u>Several years</u>	
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.			DUE TO (b) <u>Generalized Arteriosclerosis</u>				Several years	
			DUE TO (c)					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>Dementia Praecox Paranoid Type</u>						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 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>June 2, 1945</u> to <u>March 19, 1960</u> and last saw her alive on <u>March 19, 1960</u> Death occurred at <u>12:30</u> p. m. on the date stated above, and to the best of my knowledge, from the causes stated.								
22a. SIGNATURE (Degree or title) <u>Leslie H. Wright M.D.</u>				22b. ADDRESS <u>State Hospital #3, Nevada Mo</u>			22c. DATE SIGNED <u>3/19/60</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE <u>March 24, 1960</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Peculiar Cemetery</u>		23d. LOCATION (City, town, or county) (State) <u>Peculiar Missouri</u>			
24. FUNERAL DIRECTOR <u>Ferry Funeral Home</u>				ADDRESS <u>Nevada, Missouri</u>		25. DATE RECD. BY LOCAL REG. <u>3-25-1960</u>	26. REGISTRAR'S SIGNATURE <u>Anna E. Perry</u>	

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

*L. Douglas Ferry*

Licensed Embalmer No. 4960

P. O. Address Nevada

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.