

RI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

60-014005

FILED VS MAR 17 1960 374

Registration District No. 374 Primary Registration District No. 6275 Registrar's No. 8

STATE FILE NUMBER

1. PLACE OF DEATH a. COUNTY <b>Worth</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Missouri</b> b. COUNTY <b>Worth</b>			
b. CITY (If outside corporate limits, give TOWNSHIP only) <b>Smith Township</b>		Length of stay in 1b <b>1 day</b>		c. CITY OR TOWN <b>Smith Township</b>		Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) <b>Smith Township</b>			Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	d. STREET ADDRESS (If outside, give location)			Reside on Farm Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <b>Mary</b> Middle <b>Elizabeth</b> Last <b>Daniels</b>				4. DATE OF DEATH <b>February 26, 1960</b> Month <b>February</b> Day <b>26</b> Year <b>1960</b>			
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>		8. DATE OF BIRTH <b>2-13-1870</b>	9. AGE (last birthday) <b>90</b>	IF UNDER 1 YEAR Months <b>0</b> Days <b>0</b> Hours <b>0</b> Min. <b>0</b>	IF UNDER 24 HR Hours <b>0</b> Min. <b>0</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housekeeper</b>			10b. KIND OF BUSINESS OR INDUSTRY <b>Own Home</b>		11. BIRTHPLACE (City and state or country) <b>Worth County</b>		12. CITIZEN OF WHAT COUNTRY <b>U. S.</b>
13a. FATHER'S NAME <b>Christopher C. Motsinger</b>			13b. MOTHER'S MAIDEN NAME <b>Cynthia Ann Vandiver</b>			14. NAME OF HUSBAND OR WIFE <b>Albert Ross Daniels</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>487-42-5513</b>		17. INFORMANT Address <b>Blaine Daniels - Grant City, Missouri</b>		
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>TOXEMIA</b> DUE TO (b) <b>ATYPICAL PNEUMONIA</b> DUE TO (c) <b>INFLUENZA</b> 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) <b>MARRED THORACIC SCOLIOSIS &amp; KYPHOSIS</b>						INTERVAL BETWEEN ONSET AND DEATH <b>4 DAYS</b> <b>19 DAYS</b> <b>20 DAYS</b>	
19. WAS AUTOPSY PERFORMED? YES <input 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 <b>1:30</b> a.m. <b>p.m.</b> 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 <b>May 19 57</b> to <b>Feb 26 1960</b> and last saw her <sup>her</sup> <sub>him</sub> alive on <b>Feb 26, 1960</b> Death occurred at <b>1:30 p.m.</b> on the date stated above, and to the best of my knowledge, from the causes stated.							
22a. SIGNATURE (Degree or title) <b>Richard J. Swift DO</b>				22b. ADDRESS <b>Grant City, Mo</b>			22c. DATE SIGNED <b>2-29-60</b>
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE <b>2-29-1960</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Kirk Cemetery</b>		23d. LOCATION (City, town, or county) (State) <b>Grant City, Missouri</b>		
24. FUNERAL DIRECTOR ADDRESS <b>Bill D. Dunfee - Grant City</b>				25. DATE RECD. BY LOCAL REG. <b>3-10-1960</b>		26. REGISTRAR'S SIGNATURE <b>Letta C. Dawson</b>	

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

VS DEC 21 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 me  
or by \_\_\_\_\_, Student Embalmer No. \_\_\_\_\_  
working under my personal supervision.

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

Signed Bill A. Duffee

Licensed Embalmer No. 4900

P. O. Address. Grant 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.