

**RI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH**  
**EILED VS APR 25 1960**

**-60-014086**  
 STATE FILE NUMBER

Registration District No. 10 Primary Registration District No. 3002 Registrar's No. 104

<b>1. PLACE OF DEATH</b> a. COUNTY <u>Audrain</u> b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Mexico, Mo.</u> Length of stay in 1b <u>16 days</u> c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>Audrain County Hospital</u> Inside Limits <input checked="" type="checkbox"/> No <input type="checkbox"/>				<b>2. USUAL RESIDENCE</b> (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Shelby</u> c. CITY OR TOWN <u>Lenoard, Mo.</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> d. STREET ADDRESS (If outside, give location) <u>Lenoard, Mo.</u> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>			
<b>3. NAME OF DECEASED</b> (Type or print) First Middle Last <u>William Garrett Kidwell</u>			<b>4. DATE OF DEATH</b> Month Day Year <u>April 15, 1960</u>				
<b>5. SEX</b> <u>Male</u>	<b>6. COLOR OR RACE</b> <u>White</u>	<b>7. Married</b> <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	<b>8. DATE OF BIRTH</b> <u>7-12-1878</u>	<b>9. AGE</b> (last birthday) <u>82</u>	IF UNDER 1 YEAR Months Days Hours Min.		
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>Farmer</u>		<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <u>Farmer</u>		<b>11. BIRTHPLACE</b> (City and state or country) <u>Danville, Ill.</u>			
<b>12. CITIZEN OF WHAT COUNTRY</b> <u>U.S.A.</u>		<b>13a. FATHER'S NAME</b> <u>Lee A. Kidwell</u>		<b>13b. MOTHER'S MAIDEN NAME</b> <u>Marthra Jane Eve</u>			
<b>14. NAME OF HUSBAND OR WIFE</b> <u>Nellie B. Kidwell</u>		<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) (If yes, give war or dates of service) <u>no</u>					
<b>16. SOCIAL SECURITY NO.</b> <u>no</u>		<b>17. INFORMANT</b> Address <u>Mrs. Nellie B. Kidwell, Lenoard</u>					
<b>18. CAUSE OF DEATH</b> (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiac Failure</u> DUE TO (b) <u>3° heart block</u> DUE TO (c) _____ Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.					INTERVAL BETWEEN ONSET AND DEATH <u>Sudden</u>		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>Renal tubulitis colon - Cholelithiasis - Choma</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		
<b>19. WAS AUTOPSY PERFORMED?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		<b>20a. ACCIDENT</b> <input type="checkbox"/> <b>SUICIDE</b> <input type="checkbox"/> <b>HOMICIDE</b> <input type="checkbox"/>		<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in PART I or PART II of item 18.)			
<b>20c. TIME OF INJURY</b> Hour Month, Day, Year a.m. p.m.							
<b>20d. INJURY OCCURRED WHILE AT WORK</b> <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		<b>20e. PLACE OF INJURY</b> (e.g., in or about home, farm, factory, street, office bldg., etc.)		<b>20f. CITY, TOWN, OR LOCATION</b> COUNTY STATE			
<b>21. I attended the deceased from</b> <u>3-31-60</u> to <u>4-15-60</u> and last saw <sup>her</sup> him alive on <u>5<sup>PM</sup> 4-15-60</u> Death occurred at <u>9:30 PM</u> on the date stated above, and to the best of my knowledge, from the causes stated.							
<b>22a. SIGNATURE</b> (Degree or title) <u>Red W. Rodas M.D.</u>			<b>22b. ADDRESS</b> <u>13 E. Monroe Mexico Mo.</u>		<b>22c. DATE SIGNED</b> <u>4-18-60</u>		
<b>23a. BURIAL, CREMATION, REMOVAL (Specify)</b> <u>Burial</u>		<b>23b. DATE</b> <u>4-18-1960</u>		<b>23c. NAME OF CEMETERY OR CREMATORY</b> <u>Church of the Brethren Lenoard, Mo.</u>			
<b>23d. LOCATION</b> (City, town, or county) (State) <u>Lenoard, Mo.</u>		<b>24. FUNERAL DIRECTOR</b> ADDRESS <u>Greening Shelbyville, Mo.</u>		<b>25. DATE RECD. BY LOCAL REG.</b> <u>April 18-1960</u>			
<b>26. REGISTRAR'S SIGNATURE</b> <u>Blanche Kelly</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 Geo. H. Whitaker

Licensed Embalmer No. 4780

P. O. Address Medico, N.J.

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.