

RI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

=60-014495

FILED VS APR 26 1960

STATE FILE NUMBER

Registration District No. 55 Primary Registration District No. 300 4080 Registrar's No. 38

1. PLACE OF DEATH a. COUNTY CARROLL		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MO. b. COUNTY CARROLL	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN NORBORNE	Length of stay in 1b 4 Months	c. CITY OR TOWN NORBORNE	Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION 202 West Ada		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) 202 West Ada
		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	

3. NAME OF DECEASED (Type or print) First EMILY Middle C. Last DELLINGER	4. DATE OF DEATH Month April Day 17 Year 1960
--	---

5. SEX Female	6. COLOR OR RACE White	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input checked="" type="checkbox"/>	8. DATE OF BIRTH 5-17-1897	9. AGE (last birthday) 62	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) housewife	10b. KIND OF BUSINESS OR INDUSTRY At Home	11. BIRTHPLACE (City and state or country) Carroll County Mo.	12. CITIZEN OF WHAT COUNTRY USA
---	---	---	---

13a. FATHER'S NAME Frank Schifferdecker	13b. MOTHER'S MAIDEN NAME Amelia Heck	14. NAME OF HUSBAND OR WIFE Unknown
---	---	---

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No	16. SOCIAL SECURITY NO.	17. INFORMANT Address Mrs. Frances King Norborne, Mo.
---	-------------------------	---

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
IMMEDIATE CAUSE (a) Cerebral Hemorrhage		2 hours
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) Cerebral Arteriosclerosis	3+ years
	DUE TO (c) Hypertension, essential	3+ years
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.)
---	---	--

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 12-18-59 to 4-17-60 and last saw her alive on 4-16-60 Death occurred at 3:00 A.M. m on the date stated above, and to the best of my knowledge, from the causes stated.	
--	--

22a. SIGNATURE (Degree or title) Joseph E. Haskell MD	22b. ADDRESS 212 South Pine St Norborne, Mo.	22c. DATE SIGNED 4-18-60
---	---	------------------------------------

23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE April 19, 1960	23c. NAME OF CEMETERY OR CREMATORY Sacred Heart Cem.	23d. LOCATION (City, town, or county) (State) Norborne, Missouri
--	------------------------------------	--	--

24. FUNERAL DIRECTOR ADDRESS Gibson Funeral Home Norborne, Mo.	25. DATE RECD. BY LOCAL REG. 4-19-60	26. REGISTRAR'S SIGNATURE Mr. Herbert Calvert
--	--	---

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

MAY 3 1962

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 James F. Gibson

Licensed Embalmer No. 5076

P. O. Address Carrollton

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.