

IRI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

60-014603

FILED VS. APR 21 1960

Registration District No. 75 Primary Registration District No. 5300 Registrar's No. 41 STATE FILE NUMBER

INDEXED

1. PLACE OF DEATH a. COUNTY <u>Clinton</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Clinton</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Osborn</u>		Length of stay in lb <u>12 years</u>	c. CITY OR TOWN <u>Osborn</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		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print) First <u>Harold</u> Middle <u>Partridge</u> Last <u>Partridge</u>			4. DATE OF DEATH Month <u>April</u> Day <u>11</u> Year <u>1960</u>		
--	--	--	---	--	--

5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <u>2/19/1898</u>	9. AGE (last birthday) <u>62</u>	IF UNDER 1 YEAR Months <u>6</u> Days <u>2</u> Hours <u>0</u> Min. <u>0</u>
-----------------------	----------------------------------	---	--------------------------------------	-------------------------------------	---

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Cemetery sexton</u>	10b. KIND OF BUSINESS OR INDUSTRY <u>none</u>	11. BIRTHPLACE (City and state or country) <u>Derby, England</u>	12. CITIZEN OF WHAT COUNTRY <u>England</u>
---	--	---	---

13a. FATHER'S NAME <u>Thomas Partridge</u>	13b. MOTHER'S MAIDEN NAME <u>Sarah Jolley</u>	14. NAME OF HUSBAND OR WIFE <u>Kate Partridge</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>494-32-5319</u>	17. INFORMANT <u>Mrs. Lloyd Edwards, Osborn, 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 Occlusion</u>		INTERVAL BETWEEN ONSET AND DEATH <u>5 min.</u>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b)	
	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 checked="" 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 <u> </u> Month, Day, Year <u> </u> a.m. <u> </u> p.m. <u> </u>

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 <u>Osborn, Missouri</u>
--	--	---

21. I attended the deceased from 5⁰⁰ a. to and last saw her/him alive on .
Death occurred at on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) <u>Edith Weaver, R.C., Coroner</u>	22b. ADDRESS <u> </u>	22c. DATE SIGNED <u>4-13-60</u>
--	-----------------------------------	------------------------------------

23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE <u>4/13/1960</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Evergreen Cemetery</u>	23d. LOCATION (City, town, or county) (State) <u>Osborn, Missouri</u>
--	-------------------------------	---	--

24. FUNERAL DIRECTOR <u>Clyon Funeral Home, Inc, Plattsburg, Mo.</u>	25. DATE RECD. BY LOCAL REG. <u>April 14 - 60</u>	26. REGISTRAR'S SIGNATURE <u>Francis D Crawford</u>
---	--	--

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

STATEMENT BY LICENSED EMBALMER

APR 26 1960

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 *Philip E. Cook*

Licensed Embalmer No. *4992*

P. O. Address *Flamingo*

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.