

DEPARTMENT OF HEALTH - STANDARD CERTIFICATE OF DEATH

=60-014753

FILED VS APR 18 1960

Registration District No. 115-116 Primary Registration District No. 3020 Registrar's No. 81

STATE FILE NUMBER

DEED

1. PLACE OF DEATH a. COUNTY <u>JRANHIA</u>				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Mo.</u> b. COUNTY <u>Gasconade</u>				
b. CITY (If outside corporate limits, give TOWNSHIP only) <u>Washington</u>		Length of stay in lb <u>2- days</u>		c. CITY OR TOWN <u>BLAND</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 <u>St. Francis Hosp.</u>			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 Middle Last <u>DORA B. TERRILL</u>				4. DATE OF DEATH Month Day Year <u>April 8 - 1960</u>				
5. SEX <u>Female</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>Feb-11-1878</u>		
9. AGE (last birthday) <u>82</u>		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HR				
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>housewife</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>own home</u>		11. BIRTHPLACE (City and state or country) <u>Gasconade County</u>		12. CITIZEN OF WHAT COUNTRY <u>U. S. A.</u>	
13a. FATHER'S NAME <u>William Rogers</u>			13b. MOTHER'S MAIDEN NAME <u>Margarett Williams</u>			14. NAME OF HUSBAND OR WIFE <u>Oliver Terrill</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>None</u>		17. INFORMANT Address <u>Richard S. Terrill - Bland - 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>Pulmonary Embolism</u> DUE TO (b) <u>Site undetermined</u> DUE TO (c) _____ Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.							INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>arteriosclerotic Heart Disease</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 Month, Day, Year a.m. p.m.								
20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" 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>4/5/58</u> to <u>4/8/60</u> and last saw him alive on <u>4/8/60</u> Death occurred at <u>11:30</u> P on the date stated above, and to the best of my knowledge, from the causes stated.								
22a. SIGNATURE (Degree or title) <u>James J. Shea M.D.</u>				22b. ADDRESS <u>Gerald Mo</u>		22c. DATE SIGNED <u>4/12/60</u>		
23a. BURIAL, CREMATION, OR REAOVAL (Specify) <u>BURIAL</u>		23b. DATE <u>April 11-1960</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Union Cemetery</u>		23d. LOCATION (City, town, or county) (State) <u>Bland - Missouri</u>		
24. GENERAL DIRECTOR <u>Chute Jersson</u>				25. DATE RECD. BY LOCAL REG. <u>4/13/60</u>		26. REGISTRAR'S SIGNATURE <u>J.P. Williams & J.C. Williams</u>		

(Licensed Embalmer's Statement on Reverse Side)

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 Chester Lassman

Licensed Embalmer No. 417

P. O. Address Bland

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.