

# RI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-60-014892

FILED VS. APR 18 1960 / 28

Registration District No. 2000 Registrar's No. 429

STATE FILE NUMBER

DEED

<b>1. PLACE OF DEATH</b> a. COUNTY <u>Greene</u>				<b>2. USUAL RESIDENCE</b> (Where deceased lived. If institution: Residence before admission) a. STATE <u>Arizona</u> b. COUNTY <u>Maricopa</u>									
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Springfield</u>		Length of stay in 1b		c. CITY OR TOWN <u>Phoenix</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>Springfield Baptist Hospital</u>			Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location) <u>3422 N. 45th Place</u>			Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>					
<b>3. NAME OF DECEASED</b> (Type or print) First <u>Katherine</u> Middle <u>Baker</u> Last <u>McKinney</u>				<b>4. DATE OF DEATH</b> Month <u>April</u> Day <u>14</u> Year <u>1960</u>									
<b>5. SEX</b> <u>Female</u>		<b>6. COLOR OR RACE</b> <u>White</u>		<b>7. Married</b> <input type="checkbox"/> <b>Never Married</b> <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/> <u>Unknown</u>		<b>8. DATE OF BIRTH</b> <u>11-11-1902</u>		<b>9. AGE</b> (last birthday) <u>57</u>		IF UNDER 1 YEAR Months _____ Days _____		IF UNDER 24 HR Hours _____ Min. _____	
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>unknown</u>			<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <u>unknown</u>			<b>11. BIRTHPLACE</b> (City and state or country) <u>Missouri</u>			<b>12. CITIZEN OF WHAT COUNTRY</b> <u>USA</u>				
<b>13a. FATHER'S NAME</b> <u>unknown</u>				<b>13b. MOTHER'S MAIDEN NAME</b> <u>unknown</u>				<b>14. NAME OF HUSBAND OR WIFE</b> <u>Unknown</u>					
<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown)				<b>16. SOCIAL SECURITY NO.</b> <u>44-14-7472</u>				<b>17. INFORMANT</b> Address <u>Hospital Records, Springfield, Mo</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>Concussion from Auto Accident</u>										INTERVAL BETWEEN ONSET AND DEATH <u>10 hrs</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) <u>DIABETES + 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					
<b>19. WAS AUTOPSY PERFORMED?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		<b>20a. ACCIDENT</b> <input checked="" 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.) <u>TWO CAR COLLISION</u>									
<b>20c. TIME OF INJURY</b> Hour <u>9:45</u> p.m.		Month, Day, Year <u>4 15 60</u>											
<b>20d. INJURY OCCURRED WHILE AT WORK</b> <input type="checkbox"/> <b>NOT WHILE AT WORK</b> <input checked="" type="checkbox"/>		<b>20e. PLACE OF INJURY</b> (e.g., in or about home, farm, factory, street, office bldg., etc.) <u>Intersection Hiways 65 + 125</u>			<b>20f. CITY, TOWN, OR LOCATION</b> <u>Greene Mo.</u>		COUNTY		STATE				
<b>21. I attended the deceased from</b> <u>13 APR 60</u> , to <u>14 APR 60</u> and last saw her <sup>her</sup> alive on <u>14 APR 60</u> Death occurred at <u>6:32</u> <u>A</u> m on the date stated above, and to the best of my knowledge, from the causes stated.													
<b>22a. SIGNATURE</b> (Degree or title) <u>J N Allen M.D.</u>					<b>22b. ADDRESS</b> <u>Springfield mo</u>					<b>22c. DATE SIGNED</b> <u>4-15-60</u>			
<b>23a. BURIAL, CREMATION, REMOVAL</b> (Specify) <u>Removal</u>		<b>23b. DATE</b> <u>4-14-1960</u>		<b>23c. NAME OF CEMETERY OR CREMATORY</b> <u>Phoenix, Arizona</u>			<b>23d. LOCATION</b> (City, town, or county) (State)						
<b>24. FUNERAL DIRECTOR</b> ADDRESS <u>Rex Rainey, Springfield, Mo.</u>				<b>25. DATE RECD. BY LOCAL REG.</b> <u>4-15-60</u>		<b>26. REGISTRAR'S SIGNATURE</b> <u>Effie E. Melton</u>							

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

0961 9

**STATEMENT BY LICENSED EMBALMER**

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by \_\_\_\_\_, Student Embalmer No. \_\_\_\_\_  
or by \_\_\_\_\_, Student Embalmer No. \_\_\_\_\_  
working under my personal supervision.

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

Signed *[Signature]*  
Licensed Embalmer No. 33

P. O. Address *[Signature]*

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.