

RI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-60-015057

LED VS APR 20 1960

138

Primary Registration District No. 5526

Registrar's No. 15

STATE FILE NUMBER

IDED

1. PLACE OF DEATH a. COUNTY <u>Hickory</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Hickory</u>				
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Stack Township</u>		Length of stay in lb <u>4 days</u>		c. CITY OR TOWN <u>Preston</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>1 Mile S of Preston</u>			Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>		d. STREET ADDRESS (If outside, give location) <u>Highway 54</u>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Rose</u> Middle <u>Etta</u> Last <u>Reser</u>				4. DATE OF DEATH Month <u>April</u> Day <u>6</u> Year <u>1960</u>				
5. SEX <u>Female</u>	6. COLOR OR RACE <u>white</u>	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>		8. DATE OF BIRTH <u>4-24-1878</u>	9. AGE (last birthday) <u>81</u>	IF UNDER 1 YEAR Months <u>11</u> Days <u>12</u> Hours <u></u> Min. <u></u>	IF UNDER 24 HR Hours <u></u> Min. <u></u>	
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>NONE</u>		11. BIRTHPLACE (City and state or country) <u>Cross Timbers Mo U.S.A.</u>		12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>	
13a. FATHER'S NAME <u>Ell Calkins</u>			13b. MOTHER'S MAIDEN NAME <u>Mary B. Williams</u>			14. NAME OF HUSBAND OR WIFE <u>J.E. Reser</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>Dewey Mabary - Preston 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>Bronchial Pneumonia</u>							INTERVAL BETWEEN ONSET AND DEATH <u>2 weeks</u>	
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <u>Senility</u>							years <u>years</u>	
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 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 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>1958</u> to <u>April 6, 1960</u> and last saw her/him alive on <u>March 30, 1960</u>				Death occurred at <u>11 A.M.</u> on the date stated above, and to the best of my knowledge, from the causes stated.				
22a. SIGNATURE (Degree or title) <u>J.R. Briggs, D.O.</u>				22b. ADDRESS <u>Wheatland, Mo</u>			22c. DATE SIGNED <u>4-13-60</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE <u>4-10-1960</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Fisher Cemetery</u>		23d. LOCATION (City, town, or county) <u>Preston, Mo</u>		(State)		
24. FUNERAL DIRECTOR <u>Silverthornway - Wheatland, Mo</u>			ADDRESS		25. DATE RECD. BY LOCAL REG. <u>4-13-1960</u>	26. REGISTRAR'S SIGNATURE <u>Mary Johnson</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 Char. Gilbert Hathaway

Licensed Embalmer No. 4267

P. O. Address Wheatland

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.