

## RI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-60-015075

FILED VS. MAY 2 1960

STATE FILE NUMBER

DED

Registration District No. 141 Primary Registration District No. 3025 Registrar's No. 71

1. PLACE OF DEATH a. COUNTY <u>Naomesset</u>				2. USUAL RESIDENCE (Where deceased lived. Institution: Residence before admission) a. STATE <u>Mo</u> b. COUNTY <u>Naomesset</u>			
b. CITY (If outside corporate limits, give TOWNSHIP only) <u>West Haven</u>		Length of stay in 1b <u>4 1/2</u>		c. CITY OR TOWN <u>West Haven</u>		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF HOSPITAL OR INSTITUTION <u>Memorial</u>			Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location) <u>Rte 1</u>		Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <u>Virgil</u> Middle <u>Walter</u> Last <u>Ashworth</u>				4. DATE OF DEATH Month <u>4</u> Day <u>16</u> Year <u>60</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>W</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>7-9-79</u>	9. AGE (last birthday) <u>80</u>	IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min. <u>  </u>		IF UNDER 24 HR Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min. <u>  </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired Auto Agent</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>N. Carolina</u>		11. BIRTHPLACE (City and state or country) <u>N. Carolina</u>		12. CITIZEN OF WHAT COUNTRY <u>USA</u>	
13a. FATHER'S NAME <u>Wm T</u>		13b. MOTHER'S MAIDEN NAME <u>Wm T</u>		13c. NAME OF HUSBAND OR WIFE <u>Domest Ashworth</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>yes</u>		16. SOCIAL SECURITY NO. <u>yes</u>		17. INFORMANT <u>Mrs V. W. Ashworth, West Haven 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>Cerebral Hemorrhage</u> DUE TO (b) <u>Cerebral Arteriosclerosis</u> DUE TO (c) <u>  </u> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.						INTERVAL BETWEEN ONSET AND DEATH <u>3 days</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>Arteriosclerosis / 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 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.) <u>Self</u>			
20c. TIME OF INJURY Hour <u>  </u> a.m. <u>  </u> p.m. <u>  </u>		Month, Day, Year <u>  </u> <u>  </u> <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.) <u>  </u>		20f. CITY, TOWN, OR LOCATION <u>  </u>		COUNTY <u>  </u> STATE <u>  </u>	
21. I attended the deceased from <u>6:00 A.</u> <u>2-1-54</u> to <u>4-16-60</u> and last saw him alive on <u>4-13-60</u> Death occurred at <u>  </u> on the date stated above, and to the best of my knowledge, from the causes stated.							
22a. SIGNATURE <u>Jack W. Wilson</u>				22b. ADDRESS <u>  </u>		22c. DATE SIGNED <u>4-23-60</u>	
23a. BURIAL CREMATION, REMOVAL (Specify) <u>  </u>		23b. DATE <u>4-18-60</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Oak Lawn</u>		23d. LOCATION (City, town, or county) (State) <u>West Haven Mo</u>	
24. FUNERAL DIRECTOR <u>Robertson</u>		ADDRESS <u>West Haven Mo</u>		25. DATE RECD. BY LOCAL REG. <u>4-26-60</u>		26. REGISTRAR'S SIGNATURE <u>Beatrice Cook</u>	

(Licensed Embalmer's Statement on Reverse Side)

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

JUL 27 1960

MAY 10

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

*A. J. Rauts*

Licensed Embalmer No. 3432

P. O. Address West

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.