

**FEDERAL DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH**

**60-015983**

**FILED VS APR 25 1960**

174

Registration District No. \_\_\_\_\_ Primary Registration District No. <sup>2085</sup> 3036

Registrar's No. 36

STATE FILE NUMBER

INDEXED

1. PLACE OF DEATH a. COUNTY <u>Lafayette</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Lafayette</u>									
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Lexington</u>		Length of stay in lb <u>1 week</u>		c. CITY OR TOWN <u>Higginsville</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>Memorial Hospital</u>			Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location) <u>107 W. 27st</u>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>						
3. NAME OF DECEASED (Type or print) First <u>Emma</u> Middle <u>Florence</u> Last <u>White</u>				4. DATE OF DEATH Month <u>April</u> Day <u>2</u> Year <u>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>10/21/1881</u>		9. AGE (last birthday) <u>78</u>		IF UNDER 1 YEAR Months _____ Days _____		IF UNDER 24 HR Hours _____ Min. _____	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Horse wife</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>own home</u>		11. BIRTHPLACE (City and state or country) <u>Waverly, Mo.</u>		12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>					
13a. FATHER'S NAME <u>Richard G. Corbin</u>				13b. MOTHER'S MAIDEN NAME <u>Julia Anne Catron</u>				14. NAME OF HUSBAND OR WIFE <u>Roy H. White</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 <u>Roy H. White</u> address <u>Higginsville, 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>										INTERVAL BETWEEN ONSET AND DEATH <u>1 week</u>			
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.										DUE TO (b) <u>Secondary Hypertension</u> <u>years</u>			
										DUE TO (c) <u>Senescent Arteriosclerosis</u> <u>years</u>			
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 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 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>March 26 - 60</u> <u>April 2 - 60</u> last saw her <u>April 1 - 60</u> alive on _____ Death occurred at <u>4:30 a.m.</u> on the date stated above, and to the best of my knowledge, from the causes stated.													
22a. SIGNATURE <u>[Signature]</u> (Degree or title) <u>M.D.</u>						22b. ADDRESS <u>Higginsville Mo</u>			22c. DATE SIGNED <u>Apr. 3-60</u>				
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>burial</u>		23b. DATE <u>Apr. 4, 1960</u>		23c. NAME OF CEMETERY OR CREMATORY <u>City</u>			23d. LOCATION (City, town, or county) <u>Higginsville Mo.</u> (State)						
24. FUNERAL DIRECTOR <u>Wieggers-Prelhof</u> ADDRESS <u>Higginsville, Mo.</u>				25. DATE RECD. BY LOCAL REG. <u>4-6-60</u>		26. REGISTRAR'S SIGNATURE <u>[Signature]</u>							

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 Roy F. Wiegman

Licensed Embalmer No. 2883

P. O. Address Higginsville

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.