

RI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

=60-016001

FILED VS APR 18 1960

STATE FILE NUMBER 8

Registration District No. 176 Primary Registration District No. 5654 Registrar's No. _____

1. PLACE OF DEATH a. COUNTY <u>Lawrence</u> b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Miller Lincoln</u> Length of stay in 1b <u>Native</u> c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>Residence</u> Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Lawrence</u> c. CITY OR TOWN <u>Miller</u> Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> d. STREET ADDRESS (If outside, give location) <u>R.F.D. # 1</u> Reside on Farm Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
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3. NAME OF DECEASED (Type or print) First <u>Leola</u> Middle <u>Bowen</u> Last <u>Baker</u>			4. DATE OF DEATH Month <u>4</u> Day <u>12</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>1-4-1877</u>	9. AGE (last birthday) <u>83</u>	IF UNDER 1 YEAR Months <u>3</u> Days <u>8</u>	IF UNDER 24 HR Hours _____ Min. _____	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farm Wife</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (City and state or country) <u>Lawrence Co. Mo. USA</u>		12. CITIZEN OF WHAT COUNTRY <u>USA</u>	
13a. FATHER'S NAME <u>Lawson H. W. Hibb</u>		13b. MOTHER'S MAIDEN NAME <u>Sarah E. Gay</u>		14. NAME OF HUSBAND OR WIFE <u>Deceased</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>Charles Baker Miller Mo.</u>		Address _____	

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>Coronary heart disease</u> DUE TO (b) <u>Coronary lesions</u> DUE TO (c) <u>less atherosclerosis - Broken hip</u> 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>Fractured hip joint</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 _____ 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>Dec 22 - 1959</u> and last saw her alive on <u>Mar 29 - 60</u> Death occurred at <u>5-10 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>W. S. Buttrick M.D.</u>		22b. ADDRESS <u>Miller, Mo</u>		22c. DATE SIGNED <u>4-16-60</u>
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE <u>4-14-1960</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Shuloh</u>	23d. LOCATION (City, town, or county) (State) <u>8 mi. E. Miller, Mo.</u>	
24. FUNERAL DIRECTOR <u>Morris - Leiman Miller Mo.</u>		25. DATE RECD. BY LOCAL REG. <u>4-14-1960</u>		26. REGISTRAR'S SIGNATURE <u>W. S. Buttrick</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 E. P. Seiman

Licensed Embalmer No. 3297

P. O. Address Miller M

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.