

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

**-60-016076**

FILED **MAY 13 1960** (18)

Primary Registration District No. **304e** Registrar's No. **905**

STATE FILE NUMBER

1. PLACE OF DEATH a. COUNTY <b>Livingston</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Missouri</b> COUNTY <b>Livingston</b>				
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>Chillicothe</b>		Length of stay in 1b <b>1 day</b>		c. CITY OR TOWN <b>Chula</b>		Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>		
c. FULL NAME OF (IF NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>Chillicothe Hospital</b>			Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location) <b>1 Mi. W. of Chula</b>		Reside on Farm Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>FREDA</b> Middle <b>DICKMAN</b> Last <b>DICKMAN</b>				4. DATE OF DEATH Month <b>MAY</b> Day <b>8</b> Year <b>1960</b>				
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>		8. DATE OF BIRTH <b>12/28/1896</b>	9. AGE (last birthday) <b>64</b>	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) <b>House wife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>At Home</b>		11. BIRTHPLACE (City and state or country) <b>Kee's Summit, Mo.</b>		12. CITIZEN OF WHAT COUNTRY <b>U.S.A.</b>		
13a. FATHER'S NAME <b>E. H. KAMPSCHMIDT</b>			13b. MOTHER'S MAIDEN NAME <b>DORA HART</b>			14. NAME OF HUSBAND OR WIFE <b>OPAL DICKMAN</b>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>NO</b>		16. SOCIAL SECURITY NO. <b>NONE</b>		17. INFORMANT <b>OPAL DICKMAN: RR#1 CHULA, MISSOURI</b> 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 artery occlusion - infarction</u> DUE TO (b) <u>Diabetes Mellitus</u> DUE TO (c) _____ Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.							INTERVAL BETWEEN ONSET AND DEATH <b>48 hr</b> <b>1 yr.</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>Pulmonary edema -</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>Aug 1955</u> to <u>May 8 1960</u> and last saw her alive on <u>May 8 1960</u> Death occurred at <u>8:10 P</u> on the date stated above, and to the best of my knowledge, from the causes stated.								
22a. SIGNATURE <u>T. J. Melazzo Do</u> (Degree or title)				22b. ADDRESS <u>Chillicothe Mo</u>		22c. DATE SIGNED <u>5-12-60</u>		
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		23b. DATE <b>5/10/60</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Resthaven Cemetery</b>		23d. LOCATION (City, town, or county) (State) <b>Chillicothe, Missouri</b>			
24. FUNERAL DIRECTOR <b>NORMAN FUNERAL HOME: Chillicothe, Mo.</b> ADDRESS				25. DATE RECD. BY LOCAL REG. <b>5-12-60</b>		26. REGISTRAR'S SIGNATURE <b>Francis B Reel</b>		

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. T. Norman*

Licensed Embalmer No. 4036

P. O. Address Chillicothe,

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.