

FEDERAL DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

60-016094

FILED VS MAY 9 1960

Registration District No. 187 Primary Registration District No. 3040 Registrar's No. 89

STATE FILE NUMBER

1. PLACE OF DEATH a. COUNTY <u>Livingston</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> COUNTY <u>St. Louis</u>				
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Wheeling</u>		Length of stay in 1b <u>5 days</u>		c. CITY OR TOWN <u>St. Louis</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			Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location) <u>702 Pine St.</u>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>JAMES</u> Middle <u>KELLEY</u> Last <u>JEFFORDS</u>				4. DATE OF DEATH Month <u>April</u> Day <u>30</u> Year <u>1960</u>				
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. Married <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>		8. DATE OF BIRTH <u>3/17/1904</u>	9. AGE (last birthday) <u>56</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>Fireman</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>Mississippi Barge Line Boats</u>		11. BIRTHPLACE (City and state or country) <u>Dycusberg, Ky.</u>		12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>	
13a. FATHER'S NAME <u>James L. Jeffords</u>			13b. MOTHER'S MAIDEN NAME <u>Minnie P. Jeffords</u>			14. NAME OF HUSBAND OR WIFE <u>NONE</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>235-289-315</u>		17. INFORMANT Address <u>Raymond Jeffords; Wheeling, 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>Cardioma of Pancreas</u>							INTERVAL BETWEEN ONSET AND DEATH <u>6 mon</u>	
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.		DUE TO (b) _____		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 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>Apr. 27, 1960</u> to <u>Apr. 30, 1960</u> and last saw ^{her} him alive on <u>Apr. 30, 1960</u> Death occurred at <u>12:01</u> <u>pm</u> on the date stated above, and to the best of my knowledge, from the causes stated.								
22a. SIGNATURE <u>Robert Bryan D.O.</u> (Degree or title)				22b. ADDRESS <u>Wheeling, Mo.</u>			22c. DATE SIGNED <u>5-2-60</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE <u>5/2/60</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Wheeling Cemetery</u>		23d. LOCATION (City, town, or county) (State) <u>Wheeling, Missouri</u>			
24. FUNERAL DIRECTOR ADDRESS <u>NORMAN FUNERAL HOME; Chillicothe, Mo.</u>				25. DATE RECD. BY LOCAL REG. <u>5/2/60</u>		26. REGISTRAR'S SIGNATURE <u>Francis B Neill</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 Elton 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.