

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

158 -60-016166

FILED VS APR 27 1960

209

3043

STATE FILE NUMBER

Registration District No. \_\_\_\_\_ Primary Registration District No. \_\_\_\_\_ Registrar's No. \_\_\_\_\_

1. PLACE OF DEATH a. COUNTY <u>Marion</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Mo.</u> b. COUNTY <u>Marion</u>					
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Hannibal</u>		Length of stay in lb <u>4 days</u>		c. CITY OR TOWN <u>Hannibal</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>Levering Hospital</u>			Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location) <u>1714 Price Ave</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>Glenn</u> Last <u>Whitehead</u>				4. DATE OF DEATH Month <u>4</u> - Day <u>21</u> - Year <u>1960</u>					
5. SEX <u>Male</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>1-22-1917</u>	9. AGE (last birthday) <u>43</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>Business Agent</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>AR&amp;L</u>		11. BIRTHPLACE (City and state or country) <u>Wellsville, Mo.</u>		12. CITIZEN OF WHAT COUNTRY <u>USA</u>		
13a. FATHER'S NAME <u>Ollie Whitehead</u>			13b. MOTHER'S MAIDEN NAME <u>Mary Stone</u>			14. NAME OF HUSBAND OR WIFE <u>Lula Whitehead</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>497-16-3556</u>		17. INFORMANT Address <u>Lula Whitehead - Hannibal, 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>Coma</u>							INTERVAL BETWEEN ONSET AND DEATH <u>4 days</u>		
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.			DUE TO (b) <u>Intercranial bleeding following auto accident</u>				4 days		
			DUE TO (c) <u>Epilepsy - Grand Mal</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 checked="" type="checkbox"/>	20a. ACCIDENT <input checked="" 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>Car accident</u>						
20c. TIME OF INJURY Hour <u>7:30 PM</u> a.m. _____ p.m. _____ Month, Day, Year <u>4/17/60</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>2800 Market St</u>		20f. CITY, TOWN, OR LOCATION <u>Hannibal</u>		COUNTY <u>Marion</u>	STATE <u>Mo.</u>
21. I attended the deceased from <u>4-17-60</u> to <u>4-21-60</u> and last saw him alive on <u>4-21-60</u>			Death occurred at <u>4:00 P</u> m on the date stated above, and to the best of my knowledge, from the causes stated.						
22a. SIGNATURE (Degree or title) <u>J. W. Watuschek M.D.</u>				22b. ADDRESS <u>1209 Broadway</u>			22c. DATE SIGNED <u>4-22-60</u>		
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE <u>4-23-1960</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Grand View Cemetery</u>		23d. LOCATION (City, town, or county) <u>Hannibal, Mo.</u>				
24. FUNERAL DIRECTOR ADDRESS <u>Clark Funeral Home - Hannibal, Mo.</u>				25. DATE RECD. BY LOCAL REG. <u>4/28/60</u>		26. REGISTRAR'S SIGNATURE <u>Dr. E.M. Lucke by Lillian M. Stroman</u>			

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

1960  
JUN 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 \_\_\_\_\_, Student Embalmer No. \_\_\_\_\_ or by \_\_\_\_\_, Student Embalmer No. \_\_\_\_\_ working under my personal supervision.

Student \_\_\_\_\_  
Signature of Student Embalmer

Signed *Ralph D. Clark*

Licensed Embalmer No. 4217  
P. O. Address Hannibal, Mo

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.