

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

**=60-016349**

**FILED VS MAY 9 1960 274**

**3052**

**173**

STATE FILE NUMBER

ENDED

1. PLACE OF DEATH a. COUNTY <b>Pettis</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MISSOURI</b> b. COUNTY <b>Pettis</b>				
b. CITY (If outside corporate limits, give TOWNSHIP only) <b>Sedalia</b>		Length of stay in 1b <b>60 years</b>		c. CITY OR TOWN <b>Sedalia</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>Bothwell Hospital</b>			Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>		d. STREET ADDRESS (If outside, give location) <b>419 East 6th Street</b>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>MABEL</b> Middle <b>F.</b> Last <b>HANDLEY</b>			4. DATE OF DEATH Month <b>April</b> Day <b>29</b> Year <b>1960</b>					
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <b>May 18, 1875</b>	9. AGE (last birthday) <b>84</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>Homemaker</b>			10b. KIND OF BUSINESS OR INDUSTRY <b>Own Home</b>	11. BIRTHPLACE (City and state or country) <b>near Fayette, Mo.</b>		12. CITIZEN OF WHAT COUNTRY <b>USA</b>		
13a. FATHER'S NAME <b>John W. Gaines</b>			13b. MOTHER'S MAIDEN NAME <b>Josephine E. Hackley</b>		14. NAME OF HUSBAND OR WIFE <b>Patrick Henry Handley</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 Address <b>Fred Handley, Overland Park, Kansas.</b>				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Chronic myocarditis</b> DUE TO (b) <b>arterio Sclerosis</b> DUE TO (c) _____ 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). <b>Fracture neck of r. humer fall at home on Feb 20 1960.</b>					PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input checked="" 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 _____ s.m. _____ p.m. _____	Month, Day, Year							
20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <b>Home</b>		20f. CITY, TOWN, OR LOCATION <b>Sedalia</b>		COUNTY <b>Pettis</b>	STATE <b>Mo.</b>		
21. I attended the deceased from <b>2-20-60</b> to <b>4-29-60</b> and last saw her <sup>her</sup> alive on <b>4/28/60</b> Death occurred at <b>2:30 AM.</b> on the date stated above, and to the best of my knowledge, from the causes stated.								
22a. SIGNATURE <b>W. W. Boyer M.D.</b> (Degree or title)				22b. ADDRESS <b>Sedalia Mo</b>		22c. DATE SIGNED <b>4/29/60</b>		
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE <b>May 3, 1960</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Crown Hill Cemetery</b>		23d. LOCATION (City, town, or county) <b>Sedalia, Missouri</b>		(State)		
24. FUNERAL DIRECTOR <b>D.W. Heckart - Sedalia, Mo.</b>			ADDRESS <b>Gillespie Funeral Home,</b>	25. DATE RECD. BY LOCAL REG. <b>May 2 1960</b>	26. REGISTRAR'S SIGNATURE <b>Frances Shelby</b>			

(Licensed Embalmer's Statement on Reverse Side)

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 \_\_\_\_\_ Signed Richard D. Conn

Signature of Student Embalmer

Licensed Embalmer No. 4703

P. O. Address Sedalia, Mo

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.