

**R.I. DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH**

**=60-018168**

**FILED VS MAY 23 1960**

STATE FILE NUMBER

Registration District No. 1 Primary Registration District No. 3000 Registrar's No. 144

1. PLACE OF DEATH a. COUNTY <b>Adair</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Mo.</b> b. COUNTY <b>Adair</b>			
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>Kirksville</b>		Length of stay in 1b <b>11 yrs</b>		c. CITY OR TOWN <b>Kirksville</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>611 N. Centennial</b>			Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <b>611 N. Centennial</b>			Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <b>Media</b> Middle <b>Elizabeth</b> Last <b>Deitrick</b>				4. DATE OF DEATH Month <b>May</b> Day <b>15</b> Year <b>1960</b>			
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. Married <input checked="" type="checkbox"/> <del>Never Married</del>	8. DATE OF BIRTH <b>4/20/96</b>	9. AGE (last birthday) <b>64</b>	IF UNDER 1 YEAR Months <input type="checkbox"/> Days <input type="checkbox"/>	IF UNDER 24 HR Hours <input type="checkbox"/> Min. <input type="checkbox"/>	
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>Chillicothe, Mo.</b>		12. CITIZEN OF WHAT COUNTRY <b>U S</b>	
13a. FATHER'S NAME <b>James Ralls</b>		13b. MOTHER'S MAIDEN NAME <b>Dollie Harris</b>		14. NAME OF HUSBAND OR WIFE <b>Ray Deitrick</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>491-14-2910</b>		17. INFORMANT Address <b>Ray Deitrick, Kirksville, Mo.</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY:						INTERVAL BETWEEN ONSET AND DEATH <b>2 hrs</b>	
IMMEDIATE CAUSE (a) <b>Coronary Occlusion</b>							
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <b>Coronary Heart Disease</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 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 <input type="checkbox"/> a.m. <input type="checkbox"/> 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.)		20f. CITY, TOWN, OR LOCATION		COUNTY STATE	
21. I attended the deceased from <b>5/5/60</b> to <b>5-15-60</b> and last saw her <sup>her</sup> <sub>him</sub> alive on <b>5/15/60</b> Death occurred on <b>5/15/60</b> <b>4:45</b> a.m. on the date stated above, and to the best of my knowledge, from the causes stated.							
22a. SIGNATURE <i>[Signature]</i> (Degree or title) <b>MD.</b>				22b. ADDRESS <b>Kirksville, Missouri</b>		22c. DATE SIGNED <b>5/16/60</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE <b>5/17/60</b>	23c. NAME OF CEMETERY <del>OK OK OK OK OK</del> <b>Highland Park</b>		23d. LOCATION (City, town, or county) (State) <b>Kirksville, Adair, Mo.</b>		
24. FUNERAL DIRECTOR <i>[Signature]</i> ADDRESS <b>Foster Memorial Home, Kirksville, Mo.</b>				25. DATE RECD. BY LOCAL REG. <b>5-17-1960</b>		26. REGISTRAR'S SIGNATURE <b>Doris W. Ratliff</b>	

DOCUMENT  
MEDICAL CERTIFICATION HILTON  
Wimp

J. J. Wimp, M.D.

**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 *Nova E. Foster*  
**Nova E. Foster**

Licensed Embalmer No. 4742

P. O. Address Kirkville, 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.