

FRI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

=60-018171

FILED VS JUN 6 1960

Registration District No. 1 Primary Registration District No. 3000 Registrar's No. 164

STATE FILE NUMBER

1. PLACE OF DEATH a. COUNTY Adair				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY Sullivan					
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Kirksville		Length of stay in lb 6 months		c. CITY OR TOWN Green City		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>			
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Community Nursing Home #2			Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location) No street address		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First Webster Middle Warren Last Eubanks				4. DATE OF DEATH Month May Day 22, Year 1960					
5. SEX Male	6. COLOR OR RACE White	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>		8. DATE OF BIRTH 5/28/1874	9. AGE (last birthday) 85	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) Farmer			10b. KIND OF BUSINESS OR INDUSTRY General farming		11. BIRTHPLACE (City and state or country) Green City, Mo.		12. CITIZEN OF WHAT COUNTRY USA		
13a. FATHER'S NAME David B. Eubanks			13b. MOTHER'S MAIDEN NAME Mary Ann Russell			14. NAME OF HUSBAND OR WIFE Eliza Jane Eubanks			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) NO			16. SOCIAL SECURITY NO. None		17. INFORMANT Address Clifford Eubanks, Green City, Mo.				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Overwhelming Toxicemia</i> DUE TO (b) <i>Intestinal Obstruction</i> DUE TO (c) <i>Inflammatory adhesions of large and small intestine unknown</i> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.							INTERVAL BETWEEN ONSET AND DEATH <i>weeks</i> <i>months</i>		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <i>Lachyria and Anarition</i>					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 checked="" 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 Month, Day, Year a.m. p.m.									
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 <i>5/5/60</i> to <i>5/22/60</i> and last saw him alive on <i>5/22/60</i> Death occurred at <i>4:35</i> <i>A</i> .m. on the date stated above, and to the best of my knowledge, from the causes stated.									
22a. SIGNATURE (Degree or title) <i>William F. Beugen, D.O.</i>				22b. ADDRESS <i>Green City Mo</i>			22c. DATE SIGNED <i>5/26/60</i>		
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE 5/24/1960	23c. NAME OF CEMETERY OR CREMATORY Burnett Cemetery			23d. LOCATION (City, town, or county) Sullivan County, Mo.				
24. FUNERAL DIRECTOR ADDRESS <i>Glen E. Kent & Son, Green City, Mo</i>				25. DATE RECD. BY LOCAL REG. <i>6-1-1960</i>		26. REGISTRAR'S SIGNATURE <i>Doris W. Ratliff</i>			

(Licensed Embalmer's Statement on Reverse Side)

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

WILLIAM F. BERGEN, D.O.

MS. W. 23 1896

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me
or by _____, Student Embalmer No. _____
working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed Karl R. Kent

Licensed Embalmer No. 4689
P. O. Address Green City.

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.