

FEDERAL DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

=60-018221

FILED VS MAY 17 1960 4

Registration District No. _____ Primary Registration District No. 4014 Registrar's No. 173

STATE FILE NUMBER

1. PLACE OF DEATH a. COUNTY Atchison				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY Holt			
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Fairfax,		Length of stay in 1b 10 weeks		c. CITY OR TOWN Oregon		Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Community Hospital			Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location)		Reside on Farm Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First MIDDLE Last HALLIE MARIE BENDER				4. DATE OF DEATH Month Day Year May 9 1960			
5. SEX Female	6. COLOR OR RACE White	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>		8. DATE OF BIRTH 3/23/97	9. AGE (last birthday) 63	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) Housewife			10b. KIND OF BUSINESS OR INDUSTRY Home	11. BIRTHPLACE (City and state or country) Maitland, Missouri		12. CITIZEN OF WHAT COUNTRY U.S.A.	
13a. FATHER'S NAME Edward Buntz			13b. MOTHER'S MAIDEN NAME Katie Hibbard		14. NAME OF HUSBAND OR WIFE Albert Bender		
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 Albert Bender, Oregon, Missouri			
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>Carcinomatosis</u> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <u>Carcinoma of rectum</u> DUE TO (c) _____						INTERVAL BETWEEN ONSET AND DEATH <u>unknown</u> <u>two years</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 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 Month, Day, Year a.m. p.m.							
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>July 1, 1952</u> to <u>May 9, 1960</u> and last saw her alive on <u>May 9, 1960</u> Death occurred at <u>2 P.M.</u> on the date stated above, and to the best of my knowledge, from the causes stated.							
22a. SIGNATURE (Degree or title) <u>D. F. Sweeney M.D.</u>				22b. ADDRESS Oregon, Missouri		22c. DATE SIGNED 5/10/60	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE 5/11/60	23c. NAME OF CEMETERY OR CREMATORY Cowan Cemetery		23d. LOCATION (City, town, or county) New Point, Missouri		(State)	
24. FUNERAL DIRECTOR ADDRESS PETTIGORN FUNERAL HOME OREGON, MO.			25. DATE RECD. BY LOCAL REG. May 13, 1960	26. REGISTRAR'S SIGNATURE <u>Therwin H. Schuler</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

James A. Crawford

Licensed Embalmer No. 4796

P. O. Address Mound 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.