

JRI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

=60-018356

FILED VS MAY 31 1960

38

Registration District No. \_\_\_\_\_ Primary Registration District No. 3006 Registrar's No. 306

STATE FILE NUMBER

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|   |                                      |   |   |
|---|--------------------------------------|---|---|
| 1. PLACE OF DEATH<br>a. COUNTY <u>Boone</u>   |                                      | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <u>Mo.</u> b. COUNTY <u>Boone</u> |   |
| b. CITY (If outside corporate limits, give TOWNSHIP only)<br>OR TOWN <u>Columbia</u>                        | Length of stay in 1b<br><u>4 yrs</u> | c. CITY OR TOWN <u>Columbia</u>   | Inside Limits<br>Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>  |
| c. FULL NAME OF (If NOT in hospital, give hospital)<br>HOSPITAL OR INSTITUTION <u>Boone County Hospital</u> |                                      | d. STREET ADDRESS (If outside, give location)<br><u>802 Hope Street</u>   | Reside on Farm<br>Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> |

|   |                                  |   |  |   |  |  |
|---|----------------------------------|---|--|---|--|--|
| 3. NAME OF DECEASED (Type or print)<br>First <u>Francois</u> Middle <u>D.</u> Last <u>Northcutt</u>             |                                  |   | 4. DATE OF DEATH<br>Month <u>5</u> Day <u>26</u> Year <u>1960</u>      |   |  |  |
| 5. SEX<br><u>Female</u>   | 6. COLOR OR RACE<br><u>White</u> | 7. Married <input type="checkbox"/> Never Married <input type="checkbox"/><br>Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/> | 8. DATE OF BIRTH<br><u>11/1/1874</u>                                   | 9. AGE (last birthday)<br><u>85</u>                   | IF UNDER 1 YEAR<br>Months _____ Days _____ | IF UNDER 24 HR<br>Hours _____ Min. _____ |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><u>Housewife</u> |                                  | 10b. KIND OF BUSINESS OR INDUSTRY<br><u>Home</u>  | 11. BIRTHPLACE (City and state or country)<br><u>Ralls County, Mo.</u> |   | 12. CITIZEN OF WHAT COUNTRY<br><u>USA</u>  |  |
| 13a. FATHER'S NAME<br><u>William Wilson</u>   |                                  | 13b. MOTHER'S MAIDEN NAME<br><u>Amada Ashburn</u>   |  | 14. NAME OF HUSBAND OR WIFE<br><u>L. C. Northcutt</u> |  |  |

|   |                                  |                                       |                               |
|---|----------------------------------|---------------------------------------|-------------------------------|
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)<br><u>No</u> | 16. SOCIAL SECURITY NO.<br>_____ | 17. INFORMANT<br><u>Mrs C E Thorp</u> | Address<br><u>Columbia Mo</u> |
|---|----------------------------------|---------------------------------------|-------------------------------|

|   |                                     |   |
|---|-------------------------------------|---|
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:                          |                                     | INTERVAL BETWEEN ONSET AND DEATH  |
| IMMEDIATE CAUSE (a) <u>Fat Embolism pulmonary artery suspected</u>  |                                     | <u>immediate</u>  |
| Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.  | DUE TO (b) <u>fracture left hip</u> | <u>24 hours</u>   |
|   | DUE TO (c) <u>Osteoporosis</u>      | <u>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.<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown |

|   |   |  |
|---|---|--|
| 19. WAS AUTOPSY PERFORMED?<br>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<br>Hour _____ a.m. _____ p.m.<br>Month, Day, Year _____                       | 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 5/27/60 to 5/26/60 and last saw her alive on 5/26/60  
Death occurred at 10 PM on the date stated above, and to the best of my knowledge, from the causes stated.

|  |                               |   |  |
|--|-------------------------------|---|--|
| 22a. SIGNATURE<br><u>Phil Fague MD</u>                     | (Degree or title)             | 22b. ADDRESS<br><u>909 Olive Ave Columbia Mo</u>              | 22c. DATE SIGNED<br><u>26 May 60</u>   |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><u>Burial</u> | 23b. DATE<br><u>5/28/1960</u> | 23c. NAME OF CEMETERY OR CREMATORY<br><u>Barkley Cemetery</u> | 23d. LOCATION (City, town, or county) (State)<br><u>New London, Missouri</u> |

|   |                                 |  |  |
|---|---------------------------------|--|--|
| 24. FUNERAL DIRECTOR<br><u>Lyman Sprinkle</u> | ADDRESS<br><u>Columbia, Mo.</u> | 25. DATE RECD. BY LOCAL REG.<br><u>May 27 1960</u> | 26. REGISTRAR'S SIGNATURE<br><u>Mrs R E Palmer</u> |
|---|---------------------------------|--|--|

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

Signed George D. Varn

Licensed Embalmer No. 4425

P. O. Address Columbus

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.