

JRL DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-60-019197

FILED VS MAY 16 1960

140

Primary Registration District No. 3024

Registrar's No. 47

STATE FILE NUMBER

INDEXED

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|--|--|--|---|
| 1. PLACE OF DEATH a. COUNTY Howard | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri COUNTY Howard | |
| b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Fayette, Missouri. | | Length of stay in lb 2 days | c. CITY OR TOWN Fayette, Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> |
| c. FULL NAME OF (IF NOT in hospital, give location) HOSPITAL OR INSTITUTION Lee Hospital | | Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> | d. STREET ADDRESS (If outside, give location) Moniteau Twp. Reside on Farm Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> |

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|--|--|--|--|--|--|--|
| 3. NAME OF DECEASED (Type or print) First WILLIAM Middle MICHEAL Last LITTLE | | | 4. DATE OF DEATH Month MAY. Day 7, Year 1960 | | | |
|--|--|--|--|--|--|--|

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|-----------------------|----------------------------------|---|--------------------------------------|-------------------------------------|---------------------------|------------------------|-------|------|
| 5. SEX Male | 6. COLOR OR RACE White | 7. Married <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/> | 8. DATE OF BIRTH 6/20/1883 | 9. AGE (last birthday) 76 | IF UNDER 1 YEAR Months | IF UNDER 24 HR Days | Hours | Min. |
|-----------------------|----------------------------------|---|--------------------------------------|-------------------------------------|---------------------------|------------------------|-------|------|

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| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farming | 10b. KIND OF BUSINESS OR INDUSTRY Self Employed | 11. BIRTHPLACE (City and state or country) Howard County, Mo. | 12. CITIZEN OF WHAT COUNTRY U.S.A. |
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| 13a. FATHER'S NAME Mike Little | 13b. MOTHER'S MAIDEN NAME Eliza Ward | 14. NAME OF HUSBAND OR WIFE ----- |
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| 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 Mrs Nora Mitchell Fayette, Mo. | Address |
|--|--|--|---------|

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| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arterial thrombosis-embolism | | INTERVAL BETWEEN ONSET AND DEATH 3 days |
| Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. | DUE TO (b) | |
| | DUE TO (c) | |

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| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (e) | 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 |
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| 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.) |
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| 20c. TIME OF INJURY Hour _____ a.m. _____ p.m. | Month, Day, Year |
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|--|--|------------------------------|--------|-------|
| 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 **1959** to **5/9/60** and last saw her alive on **5/9/60**
Death occurred at **12 P** m on the date stated above, and to the best of my knowledge, from the causes stated.

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|---|------------------------------------|------------------------------------|
| 22a. SIGNATURE M P Leach MD (Degree or title) | 22b. ADDRESS Fayette, Mo | 22c. DATE SIGNED 5/13/60 |
|---|------------------------------------|------------------------------------|

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|--|------------------------------|---|---|
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial | 23b. DATE 5/9/1960 | 23c. NAME OF CEMETERY OR CREMATORY Ashland Cemetery | 23d. LOCATION (City, town, or county) Fayette, Missouri (State) |
|--|------------------------------|---|---|

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|---|--------------------------------|--|---|
| 24. FUNERAL DIRECTOR Kathleen A. Cass | ADDRESS Fayette, Mo. | 25. DATE RECD. BY LOCAL REG. 5-14-60 | 26. REGISTRAR'S SIGNATURE Katherine Welch |
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(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

~~_____~~ _____, Student Embalmer No. _____

working under my personal supervision.

Student _____

Signature of Student Embalmer

Signed

Ralph A. Carter

Licensed Embalmer No. 334

P. O. Address Jayette

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.