

JRI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

=60-020041

FILED VS. MAY 24 1960

167

Primary Registration District No. 3040

Registrar's No. 99

STATE FILE NUMBER

INDEXED

| | | | |
|--|---|---|--|
| 1. PLACE OF DEATH a. COUNTY <u>Livingston</u> | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MO</u> b. COUNTY <u>Livingston</u> | |
| b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Chillicothe</u> | | Length of stay in 1b <u>2 Wks</u> | c. CITY OR TOWN <u>Chillicothe</u> Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/> |
| c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>234 Clay</u> | | Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/> | d. STREET ADDRESS (If outside, give location) <u>1402 Alexander</u> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> |
| 3. NAME OF DECEASED (Type or print) First <u>ELLA</u> Middle <u>HOUSE</u> Last <u>SWARTZ</u> | | | 4. DATE OF DEATH Month <u>MAY</u> Day <u>13</u> Year <u>1960</u> |
| 5. SEX <u>F</u> | 6. COLOR OR RACE <u>W</u> | 7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/> | 8. DATE OF BIRTH <u>Feb. 20, 1894</u> |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u> | | 10b. KIND OF BUSINESS OR INDUSTRY <u>Home</u> | 9. AGE (last birthday) <u>66</u> IF UNDER 1 YEAR Months Days Hours Min. IF UNDER 24 HR |
| 11. BIRTHPLACE (City and state or country) <u>Leola MO</u> | | 12. CITIZEN OF WHAT COUNTRY <u>U.S.A</u> | |
| 13a. FATHER'S NAME <u>Unknown Mueck</u> | | 13b. MOTHER'S MAIDEN NAME <u>Luna Hawkins</u> | |
| 14. NAME OF HUSBAND OR WIFE <u>Deceased</u> | | 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u> | |
| 16. SOCIAL SECURITY NO. <u>513-05-9872</u> | | 17. INFORMANT <u>Mrs. Wade Walden Chillicothe Mo</u> Address | |
| 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>Cerebral Thrombosis</u> DUE TO (b) <u>Arteriosclerosis</u> DUE TO (c) _____ Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. | | | INTERVAL BETWEEN ONSET AND DEATH <u>24 hr.</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>April 1960</u> to <u>May 13-1960</u> and last saw her <u>alive</u> on <u>May 12-1960</u> Death occurred at <u>3:30 a</u> m on the date stated above, and to the best of my knowledge, from the causes stated. | | | |
| 22a. SIGNATURE <u>M. Lucius DO</u> (Degree or title) | | 22b. ADDRESS <u>Chillicothe</u> | 22c. DATE SIGNED <u>5-15-60</u> |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | 23b. DATE <u>May 15-60</u> | 23c. NAME OF CEMETERY OR CREMATORY <u>Edgewood</u> | 23d. LOCATION (City, town, or county) (State) <u>Chillicothe MO.</u> |
| 24. FUNERAL DIRECTOR <u>B. J. Spidley, Chillicothe Mo</u> | | 25. DATE RECD. BY LOCAL REG. <u>5-15-60</u> | 26. REGISTRAR'S SIGNATURE <u>Francis B Neill</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

B. J. Lindley

Licensed Embalmer No. 482

P. O. Address Chillico

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.