

FRI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

=60-020055

FILED VS MAY 16 1960

Registration District No. 200 Primary Registration District No. 3041 Registrar's No. 91

STATE FILE NUMBER

| | | | |
|---|--|---|---|
| 1. PLACE OF DEATH a. COUNTY <u>Macon</u> | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Mo.</u> b. COUNTY <u>Macon</u> | |
| b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Macon</u> | | Length of stay in lb <u>6 Mon.</u> | c. CITY OR TOWN <u>Macon</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>21 Maple Lane</u> | | Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> | d. STREET ADDRESS (If outside, give location) <u>21 Maple Lane</u> Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/> |

| | | | | | |
|---|----------------------------------|---|---|---|--|
| 3. NAME OF DECEASED (Type or print) First Middle Last <u>Amy Letelia Gates</u> | | | 4. DATE OF DEATH Month Day Year <u>May 10, 1960</u> | | |
| 5. SEX <u>Female</u> | 6. COLOR OR RACE <u>White</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>3/2/1869</u> | 9. AGE (last birthday) <u>91</u> | IF UNDER 1 YEAR IF UNDER 24 HR Months Days Hours Min. |
| 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 --- | 11. BIRTHPLACE (City and state or country) <u>Macon County, Mo</u> | | 12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u> |
| 13a. FATHER'S NAME <u>Mark White</u> | | 13b. MOTHER'S MAIDEN NAME <u>Serelda Wright</u> | | 14. NAME OF HUSBAND OR WIFE <u>Mo.</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>No.</u> | 17. INFORMANT Address <u>E.C. Nuxell Macon, Mo.</u> | | |

| | | |
|---|---|--|
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: | | INTERVAL BETWEEN ONSET AND DEATH |
| IMMEDIATE CAUSE (a) <u>debilitation and inanition</u> | | <u>1 mo.</u> |
| Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. | DUE TO (b) <u>senile psychosis</u> | <u>2 yr</u> |
| | DUE TO (c) <u>generalized and cerebral arteriosclerosis</u> | <u>unknown</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 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 a.m. p.m. 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 1958 to Apr. 10, 1960 and last saw ^{her} him alive on Apr. 10, 1960
Death occurred at 3:10 P.m. on the date stated above, and to the best of my knowledge, from the causes stated.

| | | |
|---|--|--|
| 22a. SIGNATURE (Degree or title) <u>Arthur L. Hudson D.O.</u> | 22b. ADDRESS <u>Macon, Missouri</u> | 22c. DATE SIGNED <u>5-13-60</u> |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | 23b. DATE <u>May 12, 1960</u> | 23c. NAME OF CEMETERY OR CREMATORY <u>Bethel Cem.</u> |
| 23d. LOCATION (City, town, or county) <u>Macon County, Mo.</u> | | (State) |

| | | | |
|---|----------------------------------|--|---|
| 24. GENERAL DIRECTOR <u>Lester Hutcheson</u> | ADDRESS <u>Macon, Mo. 513</u> | 25. DATE RECD. BY LOCAL REG. <u>160</u> | 26. REGISTRAR'S SIGNATURE <u>Ruth M. Neely</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 Charles L. Hutton

Licensed Embalmer No. 4577

P. O. Address Macow, Pa

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.