

RI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

=60-020083

FILED VS JUN 2 1960

Registration District No. 207 Primary Registration District No. _____ Registrar's No. 24

STATE FILE NUMBER

| | | | | | | | | | |
|---|-------------------------------|---|--|--|--|--|---|---|--|
| 1. PLACE OF DEATH a. COUNTY <u>Maries Co</u> | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MO.</u> b. COUNTY <u>Phelps</u> | | | | | |
| b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Rural</u> | | Length of stay in 1b <u>1 day</u> | | c. CITY OR TOWN <u>Rural</u> | | Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> | | | |
| c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>AT home</u> | | | Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> | | d. STREET ADDRESS (If outside, give location) <u>✓</u> | | | Reside on Farm Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) First <u>HANS</u> Middle <u>J.</u> Last <u>SCOUBY</u> | | | | 4. DATE OF DEATH Month <u>5</u> Day <u>23</u> Year <u>'60</u> | | | | | |
| 5. SEX <u>male</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>9-29-1889</u> | 9. AGE (last birthday) <u>90</u> | IF UNDER 1 YEAR Months <u>7</u> Days <u>24</u> | | IF UNDER 24 HR Hours <u> </u> Min. <u> </u> | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired farmer</u> | | | 10b. KIND OF BUSINESS OR INDUSTRY <u>✓</u> | | 11. BIRTHPLACE (City and state or country) <u>Callaway Co. MO</u> | | 12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u> | | |
| 13a. FATHER'S NAME <u>Jver Scouby</u> | | | 13b. MOTHER'S MAIDEN NAME <u>DO NOT KNOW -</u> | | | 14. NAME OF HUSBAND OR WIFE <u>METTA Scouby</u> | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>✓</u> | | | 16. SOCIAL SECURITY NO. <u>-</u> | | 17. INFORMANT <u>Mrs. Ralph Kavis - St. James, MO</u> Address <u>V.R.R.</u> | | | | |

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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: | | | | | | | | INTERVAL BETWEEN ONSET AND DEATH | |
| IMMEDIATE CAUSE (a) <u>Cerebral hemorrhage</u> | | | | | | | | <u>0</u> | |
| Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. | | | | | | | | DUE TO (b) <u>Hypertension about</u> | |
| | | | | | | | | DUE TO (c) <u>8 years</u> | |

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| 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 | | | |
|---|--|--|--|--|--|--|--|--|--|

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|---|--|--|--|--|--|--|--------------|--|-------------|--|
| 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 <u>H.</u> | | COUNTY _____ | | STATE _____ | |

21. I attended the deceased from June 20, 1956 to May 23, 1960 and last saw him alive on January 10, 1960
Death occurred at May 23, 1960 at 10:15 A on the date stated above, and to the best of my knowledge, from the causes stated.

| | | | | | | | | | |
|---|--|---------------------------|--|---|--|---|--|--|--|
| 22a. SIGNATURE <u>C.V. Hammler, M.D.</u> (Degree or title) | | | 22b. ADDRESS <u>St. James, Mo.</u> | | | 22c. DATE SIGNED <u>5-25-'60</u> | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | | 23b. DATE <u>5-26-'60</u> | 23c. NAME OF CEMETERY OR CREMATORY <u>High Gate Cemetery</u> | | | 23d. LOCATION (City, town, or county) (State) <u>Maries Co. MO.</u> | | | |
| 24. FUNERAL DIRECTOR <u>Oral E. Lueder - St James, MO</u> ADDRESS | | | | 25. DATE RECD. BY LOCAL REG. <u>May 28-60</u> | | 26. REGISTRAR'S SIGNATURE <u>Nozelle Hutchins</u> | | | |

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

Handwritten text, possibly a name or address, written upside down.

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 *Orel E. Lickhite*

Licensed Embalmer No. 3540
P. O. Address *St. James*

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.

Handwritten notes and markings on the left margin, including "0" and "B-20-2".