

# FRI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-60-020109

FILED VS JUN 8 1960

Registration District No. 209 Primary Registration District No. 3043 Registrar's No. 218

STATE FILE NUMBER

<b>1. PLACE OF DEATH</b> a. COUNTY <u>MARION</u> b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>HANNIBAL</u> Length of stay in 1b <u>16 Days</u>		<b>2. USUAL RESIDENCE</b> (Where deceased lived. If institution: Residence before admission) a. STATE <u>MISSOURI</u> b. COUNTY <u>MONROE</u> c. CITY OR TOWN <u>MONROE CITY</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> d. STREET ADDRESS (If outside, give location) <u>S.OAK STREET</u> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>					
<b>3. NAME OF DECEASED</b> (Type or print) First <u>FRANK</u> Middle <u>M.</u> Last <u>JAMES</u>		<b>4. DATE OF DEATH</b> Month <u>MAY</u> Day <u>29</u> Year <u>1960</u>					
<b>5. SEX</b> <u>MALE</u>	<b>6. COLOR OR RACE</b> <u>WHITE</u>	<b>7. Married</b> <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>	<b>8. DATE OF BIRTH</b> <u>10-30-1874</u>	<b>9. AGE</b> (last birthday) <u>85</u>	IF UNDER 1 YEAR Months _____ Days _____	IF UNDER 24 HR Hours _____ Min. _____	
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life even if retired) <u>FARMER (RETIRED)</u>		<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <u>MONROE COUNTY, MO</u>		<b>11. BIRTHPLACE</b> (City and state or country) <u>U.S.A.</u>		<b>12. CITIZEN OF WHAT COUNTRY</b> <u>U.S.A.</u>	
<b>13a. FATHER'S NAME</b> <u>JOSHUA JAMES</u>			<b>13b. MOTHER'S MAIDEN NAME</b> <u>ARMANDA GENTRY</u>		<b>14. NAME OF HUSBAND OR WIFE</b> <u>Edith James</u>		
<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) (If yes, give war or dates of service) <u>NO</u>			<b>16. SOCIAL SECURITY NO.</b> <u>INFORMANT</u> <u>Mrs J. O. Casman Stouville, Mo</u>				

<b>18. CAUSE OF DEATH</b> (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pulmonary embolism</u> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <u>Thrombosis legs</u> DUE TO (c) <u>Cardiac decompensation</u>						INTERVAL BETWEEN ONSET AND DEATH <u>2 days</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		

<b>19. WAS AUTOPSY PERFORMED?</b> YES <input type="checkbox"/> NO <input type="checkbox"/>	<b>20a. ACCIDENT</b> <input type="checkbox"/> <b>SUICIDE</b> <input type="checkbox"/> <b>HOMICIDE</b> <input type="checkbox"/>	<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in PART I or PART II of item 18.)			
<b>20c. TIME OF INJURY</b> Hour _____ a.m. _____ p.m. Month, Day, Year _____	<b>20d. INJURY OCCURRED WHILE AT WORK</b> <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	<b>20e. PLACE OF INJURY</b> (e.g., in or about home, farm, factory, street, office bldg., etc.)	<b>20f. CITY, TOWN, OR LOCATION</b>	<b>COUNTY</b>	<b>STATE</b>

21. I attended the deceased from 15 May 1960 to 29 May 1960 and last saw her/him alive on 29 May 1960  
 Death occurred at 1.25 A.M. on the date stated above, and to the best of my knowledge, from the causes stated.

<b>22a. SIGNATURE</b> (Degree or title) <u>Wyneth Hamlin MD</u>	<b>22b. ADDRESS</b> <u>Hannibal mo.</u>	<b>22c. DATE SIGNED</b> <u>6/5/60</u>
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<b>23a. BURIAL, CREMATION, REMOVAL (Specify)</b> <u>BURIAL</u>	<b>23b. DATE</b> <u>6-1-60</u>	<b>23c. NAME OF CEMETERY OR CREMATORY</b> <u>St JUDES CEMETERY</u>	<b>23d. LOCATION</b> (City, town, or county) (State) <u>MONROE CITY, MO</u>
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<b>24. FUNERAL DIRECTOR</b> ADDRESS <u>Wilson &amp; Son Monroe City Mo</u>	<b>25. DATE RECD. BY LOCAL REG.</b> <u>6/6/60</u>	<b>26. REGISTRAR'S SIGNATURE</b> <u>Dr. E. M. Lucke by Gillian M. Korman</u>
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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 me, Student Embalmer No. \_\_\_\_\_

working under my personal supervision.

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

Signed Leslie L. Wilson

Licensed Embalmer No. 3014

P. O. Address Manassas City

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to do so 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.