

**JRI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH**

**-60-020223**

**FILED VS JUN 8 1960**

245

Primary Registration District No. 5834

Registrar's No. 51

STATE FILE NUMBER

INDEXED

1. PLACE OF DEATH				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)					
a. COUNTY <b>Newton</b>		b. CITY (if outside corporate limits, give TOWNSHIP only) OR TOWN <b>Diamond (Marion Twp)</b>		a. STATE <b>Missouri</b>		b. COUNTY <b>Newton</b>			
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>--</b>		Length of stay in 1b <b>15 yrs</b>		c. CITY OR TOWN <b>Diamond</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>			
		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS <b>--</b>		(If outside, give location) Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)				4. DATE OF DEATH					
First <b>Martha</b>		Middle <b>Gertrude</b>		Last <b>Glover</b>		Month Day Year <b>June 1 1960</b>			
5. SEX <b>female</b>		6. COLOR OR RACE <b>white</b>		7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>		8. DATE OF BIRTH <b>11-14-74</b>			
				9. AGE (last birthday) <b>85</b>		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) <b>at home</b>			10b. KIND OF BUSINESS OR INDUSTRY <b>at home</b>		11. BIRTHPLACE (City and state or country) <b>Dade County, Mo.</b>		12. CITIZEN OF WHAT COUNTRY <b>USA</b>		
13a. FATHER'S NAME <b>R. M. Irwin</b>			13b. MOTHER'S MAIDEN NAME <b>Susan Ann Proctor</b>			14. NAME OF HUSBAND OR WIFE <b>James Franklin Glover</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b>			16. SOCIAL SECURITY NO. <b>None</b>		17. INFORMANT Address <b>Miss Susan Glover, Diamond, Mo.</b>				
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) <b>Carcinoma of the Rectum - far advanced metastases</b>							<b>Unknown</b>		
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.									
DUE TO (b)									
DUE TO (c)									
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <b>Arteriosclerotic Heart Disease</b>						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 s.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 <b>July 16, 1959</b> to <b>6-1-60</b> and last saw her alive on <b>5-21-60</b> Death occurred at <b>8:30 P</b> on the date stated above, and to the best of my knowledge, from the causes stated.									
22a. SIGNATURE (Degree or title) <b>Richard R. Collier</b>				22b. ADDRESS <b>M. D. Carthage, Mo.</b>			22c. DATE SIGNED <b>6-2-60</b>		
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>burial</b>		23b. DATE <b>6-4-60</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Park Cemetery</b>		23d. LOCATION (City, town, or county) (State) <b>Carthage, Mo</b>			
24. FUNERAL DIRECTOR ADDRESS <b>Knell Mortuary, Carthage, Mo.</b>				25. DATE RECD. BY LOCAL REG. <b>6/3/60</b>		26. REGISTRAR'S SIGNATURE <b>Melvin C. Bowman, M.D.</b> <i>pu R.H.</i>			

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 Geo. C. Pugh

Licensed Embalmer No. 473

P. O. Address Carthage,

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.