

JRI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-60-020429

FILED VS JUN 7 1960

290

Primary Registration District No. 4427

Registrar's No. 45

STATE FILE NUMBER

NDED

1. PLACE OF DEATH a. COUNTY <i>Pulaski</i>			2. USUAL RESIDENCE (Where deceased lived if institution; Residence before admission) a. STATE <i>Mo.</i> b. COUNTY <i>Texas</i>		
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <i>Waynesville</i>		Length of stay in 1b	c. CITY OR TOWN <i>Houston</i>		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF DECEASED (NOT in hospital, give location) HOSPITAL OR INSTITUTION <i>Waynesville</i>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location)		Reside on Farm Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <i>Elsie</i> Middle <i>Allen</i> Last <i>Downs</i>			4. DATE OF DEATH Month <i>5</i> Day <i>6</i> Year <i>1960</i>		
5. SEX <i>Female</i>	6. COLOR OR RACE <i>White</i>	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <i>1889</i>	9. AGE (last birthday) <i>70</i>	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Nurse</i>		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and state or country) <i>Salt, Mo.</i>	12. CITIZEN OF WHAT COUNTRY <i>U. S. A.</i>	
13a. FATHER'S NAME <i>Steve Allen</i>		13b. MOTHER'S MAIDEN NAME <i>Tillie Fleishman</i>		14. NAME OF HUSBAND OR WIFE <i>Ben H. Downs</i>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes <input type="checkbox"/> or unknown) (If yes, give war or dates of service) <i>No</i>		16. SOCIAL SECURITY NO. <i>488-149512</i>	17. INFORMANT Address <i>Ben H. Downs, Houston, Mo.</i>		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cardiac + pulmonary arrest.</i> DUE TO (b) <i>pulmonary thrombosis</i> DUE TO (c) <i>pulmonary embolus.</i> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.					INTERVAL BETWEEN ONSET AND DEATH <i>Immediate</i>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <i>8 days after surgery for cholelithiasis</i>				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 <i>7:30</i> a.m. p.m.	Month, Day, Year <i>4-28-60</i>				
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 <i>4-28-60</i> to <i>5-6-60</i> and last saw her <i>alive</i> on <i>5-5-60</i> . Death occurred at <i>7:30</i> P. m on the date stated above, and to the best of my knowledge, from the causes stated.					
22a. SIGNATURE <i>B J Myers DO.</i> (Degree or title)			22b. ADDRESS <i>Ficking, Mo.</i>		22c. DATE SIGNED <i>5-11-60</i>
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Removal</i>	23b. DATE <i>5-10-60</i>	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION (City, town, or county) (State) <i>city limits of Salt, Mo.</i>		
24. FUNERAL DIRECTOR <i>L. F. Evans</i> ADDRESS		25. DATE RECD. BY LOCAL REG. <i>5-16-60</i>	25. REGISTRAR'S SIGNATURE <i>Wanda Hall Anderson</i>		

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

STATEMENT BY LICENSED EMBALMER

JUN 7 1951

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 *Levell C. Craig*

Licensed Embalmer No. *4769*

P. O. Address *W. H. ...*

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.