

IRL DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

=60-020435

FILED VS MAY 18 1960

290

Registration District No. _____ Primary Registration District No. 4429 Registrar's No. 59

STATE FILE NUMBER

UNDED

1. PLACE OF DEATH a. COUNTY Pulaski		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri COUNTY Pulaski	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Waynesville, Mo.		Length of stay in 1b	c. CITY OR TOWN Richland, Missouri
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Way. General Hosp.		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) Rural Rt. #
Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>			

3. NAME OF DECEASED (Type or print) First William Middle ----- Last Remington.	4. DATE OF DEATH Month April Day 28 Year 1960
--------------------------------------------------------------------------------------------------------	-----------------------------------------------------------------------

5. SEX Male	6. COLOR OR RACE White.	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH Unknown.	9. AGE (last birthday) 81	IF UNDER 1 YEAR Months _____ Days _____	IF UNDER 24 HR Hours _____ Min. _____
--------------------	--------------------------------	-------------------------------------------------------------------------------------------------------------------------------------------------------------	----------------------------------	----------------------------------	--------------------------------------------	------------------------------------------

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Salesman.	10b. KIND OF BUSINESS OR INDUSTRY -----	11. BIRTHPLACE (City and state or country) New York.	12. CITIZEN OF WHAT COUNTRY U.S.A.
-----------------------------------------------------------------------------------------------------------------	---------------------------------------------------	----------------------------------------------------------------	----------------------------------------------

13a. FATHER'S NAME Unknown.	13b. MOTHER'S MAIDEN NAME Unknown.	14. NAME OF HUSBAND OR WIFE Grace "Derry" Remington
---------------------------------------	----------------------------------------------	---------------------------------------------------------------

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No	16. SOCIAL SECURITY NO. None.	17. INFORMANT Jack Derry	Address 716 S. Illinois St. Springfield, Ill
-----------------------------------------------------------------------------------------------------------------------	-----------------------------------------	------------------------------------	--------------------------------------------------------

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 3 hrs
IMMEDIATE CAUSE (a) Pulmonary Embolus			
DUE TO (b) Blood Clot			
DUE TO (c) Prostatic Surgery			
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 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 _____ 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 4-13-60 to 4-28-60 and last saw her/him alive on 4-28-60 Death occurred at 5:08 P. on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE L. H. Myers (Degree or title) D.O.	22b. ADDRESS Richland, Missouri	22c. DATE SIGNED 4/30/60
--------------------------------------------------------------------	-------------------------------------------	------------------------------------

23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE 5/1/60	23c. NAME OF CEMETERY OR CREMATORY Oaklawn Cemetery	23d. LOCATION (City, town, or county) (State) Richland, Missouri
------------------------------------------------------------	----------------------------	---------------------------------------------------------------	----------------------------------------------------------------------------

24. FUNERAL DIRECTOR'S NAME Hepler's Funeral Home	ADDRESS Richland, Mo	25. DATE RECD. BY LOCAL REG. 5-1-60	26. REGISTRAR'S SIGNATURE Paula Ann Anderson
-------------------------------------------------------------	--------------------------------	-----------------------------------------------	--------------------------------------------------------

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

VS MAY 19 1960 SA

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

Clarence Moss

Licensed Embalmer No. *4896*

P. O. Address *Waynesville,*

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