

JRI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

FILED VS JUN 22 1960

=60-022556

STATE FILE NUMBER

Registration District No. 55 Primary Registration District No. 3011 Registrar's No. 62

NDED

1. PLACE OF DEATH a. COUNTY <u>Carroll</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Carroll</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Carrollton</u>		Length of stay in lb <u>4 days</u>	c. CITY OR TOWN <u>Carrollton</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>Bales Hospital</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <u>R.F.D. # 2</u> Reside on Farm Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>

3. NAME OF DECEASED (Type or print) First <u>Berta</u> Middle <u>Peltier</u> Last <u>Peltier</u>			4. DATE OF DEATH Month <u>6-</u> Day <u>15</u> Year <u>1960</u>		
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <u>2-27-60</u>	9. AGE (last birthday) <u>73</u>	IF UNDER 1 YEAR Months <u>3</u> Days <u>18</u>

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>House Wife</u>	10b. KIND OF BUSINESS OR INDUSTRY <u>House Work</u>	11. BIRTHPLACE (City and state or country) <u>Wakenda Missouri</u>	12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>
---	---	--	---

13a. FATHER'S NAME <u>Charles Gorman</u>	13b. MOTHER'S MAIDEN NAME <u>Jennie Ryan</u>	14. NAME OF HUSBAND OR WIFE <u>John Peltier</u>
--	--	---

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>no</u>	16. SOCIAL SECURITY NO. <u>None</u>	17. INFORMANT Address <u>John Peltier (Carrollton Mo.)</u>
--	-------------------------------------	--

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Mesenteric thrombosis</u>		INTERVAL BETWEEN ONSET AND DEATH <u>2 days</u> <u>64 years</u> <u>6 years</u>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) <u>Burghes Disease</u>	
	DUE TO (c) <u>Congestive heart failure</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 checked="" 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 1958 to June 69 and last saw her alive on 15 June 1960  
Death occurred at Bales Hospital P m on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE <u>E W Allen</u> (Deceased or title) <u>MD</u>	22b. ADDRESS <u>Carrollton Mo</u>	22c. DATE SIGNED <u>20 June 60</u>
---	-----------------------------------	------------------------------------

23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE <u>6-18-60</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Oak Hill Cemetery</u>	23d. LOCATION (City, town, or county) (State) <u>Carrollton Mo.</u>
---	--------------------------	---	---

24. FUNERAL DIRECTOR ADDRESS <u>Marshall F. Home (Carrollton Mo.)</u>	25. DATE RECD. BY LOCAL REG. <u>6-21-60</u>	26. REGISTRAR'S SIGNATURE <u>Mar Herbert Calvert</u>
---	---	--

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 R. M. Marshall

Licensed Embalmer No. 2525

P. O. Address Carrollton

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.