

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

FILED VS JUN 29 1960

**=60-022593**  
STATE FILE NUMBER

Registration District No. 10 Primary Registration District No. \_\_\_\_\_ Registrar's No. 39

INDEXED

|   |                                  |   |   |  |  |  |                              |
|---|----------------------------------|---|---|--|--|--|------------------------------|
| 1. PLACE OF DEATH   |                                  |   |   | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)        |  |  |                              |
| a. COUNTY<br><b>Clark County</b>  |                                  | b. CITY (If outside corporate limits, give TOWNSHIP only)<br>OR<br>TOWN<br><b>Alexandria, Mo.</b>   |   | a. STATE<br><b>Mo.</b>   |  | b. COUNTY<br><b>Clark</b>  |                              |
| c. FULL NAME OF (IF NOT in hospital, give location)<br>HOSPITAL OR<br>INSTITUTION<br><b>R. R. #1</b>  |                                  | Length of stay in lb<br>Inside Limits<br>Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>  |   | c. CITY<br>OR<br>TOWN<br><b>Alexandria, Mo.</b>  |  | Inside Limits<br>Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> |                              |
| d. STREET<br>ADDRESS<br><b>R. R. #1</b>   |                                  | Reside on Farm<br>Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>   |   |  |  |  |                              |
| 3. NAME OF DECEASED (Type or print)   |                                  |   | 4. DATE OF DEATH                              |  |  | Month Day Year   |                              |
| First Middle Last<br><b>Mabel Everman</b>   |                                  |   | <b>6 19 60</b>                                |  |  |  |                              |
| 5. SEX<br><b>Female</b>   | 6. COLOR OR RACE<br><b>White</b> | 7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/><br>Widowed <input type="checkbox"/> Divorced <input type="checkbox"/> | 8. DATE OF BIRTH<br><b>5/28/1898</b>          | 9. AGE (last birthday)<br><b>62</b>  | IF UNDER 1 YEAR<br>Months Days Hours Min.  |  | IF UNDER 24 HR<br>Hours Min. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Housewife</b>   |                                  | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>Own Home</b>  |   | 11. BIRTHPLACE (City and state or country)<br><b>Clark County, Mo.</b>                       |  | 12. CITIZEN OF WHAT COUNTRY<br><b>U.S.A</b>  |                              |
| 13a. FATHER'S NAME<br><b>Charles Howell</b>   |                                  |   | 13b. MOTHER'S MAIDEN NAME<br><b>Addie Nye</b> |  | 14. NAME OF HUSBAND OR WIFE<br><b>Lester Everman</b>   |  |                              |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)<br><b>No.</b>  |                                  | 16. SOCIAL SECURITY NO.   |   | 17. INFORMANT Address<br><b>Lester Everman Alexandria, Mo.</b>                               |  |  |                              |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Coronary Thrombosis</b>  |                                  |   |   |  |  | INTERVAL BETWEEN ONSET AND DEATH<br><b>24 hr</b>                                     |                              |
| Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.<br>DUE TO (b)<br>DUE TO (c)  |                                  |   |   |  |  |  |                              |
| 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.<br><input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown |  |                              |
| 19. WAS AUTOPSY PERFORMED?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |                                  | 20a. ACCIDENT SUICIDE HOMICIDE<br><input type="checkbox"/> <input type="checkbox"/> <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<br>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 _____ to _____ and last saw her/him alive on _____<br>Death occurred at <b>6:30 A</b> m on the date stated above, and to the best of my knowledge, from the causes stated. |                                  |   |   |  |  |  |                              |
| 22. SIGNATURE (Degree or title)<br><b>J. Channing D. Coroner</b>  |                                  |   | 22b. ADDRESS<br><b>Kahoka Mo.</b>             |  |  | 22c. DATE SIGNED<br><b>6-20-60</b>   |                              |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>  |                                  | 23b. DATE<br><b>6/22/60</b>   |   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Sands Cemetery</b>                                  |  | 23d. LOCATION (City, town, or county) (State)<br><b>St. Francoisville, Mo.</b>       |                              |
| 24. FUNERAL DIRECTOR ADDRESS<br><b>Delbert Shaffer Kahoka, Mo.</b>  |                                  | 25. DATE RECD. BY LOCAL REG.<br><b>6-20-60</b>  |   | 26. REGISTRAR'S SIGNATURE<br><i>[Signature]</i>  |  |  |                              |

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

JUN 30 1960

**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 *P. T. Shaffer*

Licensed Embalmer No. 5063

P. O. Address Wakarusa, Mo

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.