

FEDERAL DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

FILED VS JUL 13 1960

=60-022718

STATE FILE NUMBER

Registration District No. 100 Primary Registration District No. 3018 Registrar's No. 55

INDEXED

1. PLACE OF DEATH a. COUNTY <u>Dent</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Dent</u>					
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Salem</u>		Length of stay in lb <u>15 yrs</u>		c. CITY OR TOWN <u>Salem</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>			
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>at 1 Missouri Ave</u>			Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location) <u>Rt 1 Missouri Ave</u>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First <u>Josephine</u> Middle <u>-</u> Last <u>Steelman</u>				4. DATE OF DEATH Month <u>July</u> Day <u>8</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>Feb 2-90</u>	9. AGE (last birthday) <u>70</u>	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) <u>housewife</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>x</u>		11. BIRTHPLACE (City and state or country) <u>Dent Co Missouri</u>		12. CITIZEN OF WHAT COUNTRY <u>U S A</u>		
13a. FATHER'S NAME <u>Joe Thompson</u>			13b. MOTHER'S MAIDEN NAME <u>Melinda Hunter</u>			14. NAME OF HUSBAND OR WIFE <u>Amos Steelman</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>x</u>		17. INFORMANT <u>Amos Steelman</u>			Address <u>Salem Mo rt 1</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a) and (b). DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>RESISTANT STAPHYLOCOCCUS INFECTION</u> <u>TOWNSILS &amp; PERITONSILARY AREAS</u> DUE TO (b) <u>STAPHYLOCOCCUS INFECTION</u> DUE TO (c) _____ INTERVAL BETWEEN ONSET AND DEATH <u>9 MO.</u>									
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>CHRONIC HYPERTENSIVE CARDIOVASCULAR DISEASE</u>					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 <u>6/28/56</u> to <u>7/7/60</u> and last saw her <u>alive</u> on <u>7/7/60</u> Death occurred at <u>11:50 P</u> on the date stated above, and to the best of my knowledge, from the causes stated.									
22a. SIGNATURE <u>L.H. Hunt M.D.</u> (Degree or title)				22b. ADDRESS <u>SALEM MO</u>			22c. DATE SIGNED <u>7/9/60</u>		
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>burial</u>		23b. DATE <u>7-10-60</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Cedar Grove Cem</u>		23d. LOCATION (City, town, or county) <u>Dent County Mo</u>				
24. FUNERAL DIRECTOR <u>Spencer Funeral Home Inc</u> ADDRESS _____				25. DATE RECD. BY LOCAL REG. <u>7/9/60</u>		26. REGISTRAR'S SIGNATURE <u>M.M. Hart M.D.</u>			

(Licensed Embalmer's Statement on Reverse Side)

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 \_\_\_\_\_, Student Embalmer No. \_\_\_\_\_  
or by \_\_\_\_\_, Student Embalmer No. \_\_\_\_\_  
working under my personal supervision.

Student \_\_\_\_\_  
Signature of Student Embalmer

Signed Carl H. Ppin

Licensed Embalmer No. 9137

P. O. Address Salem

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