

# JRI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

**=60-023701**

FILED VS. JUL 5 1960 383

Registration District No. 5655 Registrar's No. 54

STATE FILE NUMBER

1. PLACE OF DEATH a. COUNTY <u>Lawrence</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Lawrence</u>						
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Mt. Vernon Mt. Vernon</u>		Length of stay in 1b		c. CITY OR TOWN <u>Mt. Vernon</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>Hedgas Nursing Home</u>			Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>		d. STREET ADDRESS (If outside, give location) <u>R.F.D.</u>		Reside on Farm Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Mary</u> Middle <u>Oliver</u> Last <u>Orr</u>				4. DATE OF DEATH Month <u>6</u> Day <u>20</u> Year <u>1960</u>						
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>		8. DATE OF BIRTH <u>2-23-1879</u>	9. AGE (last birthday) <u>81</u>	IF UNDER 1 YEAR Months <u>3</u> Days <u>14</u>	IF UNDER 24 HR Hours <u></u> Min. <u></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		11. BIRTHPLACE (City and state or country) <u>Lawrence Co. Mo.</u>		12. CITIZEN OF WHAT COUNTRY <u>USA</u>			
13a. FATHER'S NAME <u>John Harris</u>			13b. MOTHER'S MAIDEN NAME <u>Emg Line McLin</u>			14. NAME OF HUSBAND OR WIFE <u>Deceased</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>B491-42-8828</u>		17. INFORMANT <u>McLin Orr Mt. Vernon Mo.</u>			Address		
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>Travascular disease of heart</u> DUE TO (b) <u>Circulatory condition.</u> DUE TO (c) <u></u> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.							INTERVAL BETWEEN ONSET AND DEATH			
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 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 <u></u> a.m. <u></u> p.m. <u></u> Month, Day, Year <u></u>			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>May-1-60</u> to <u>6-20-60</u> and last saw her alive on <u>June-5-60</u> Death occurred at <u>1:30 PM</u> on the date stated above, and to the best of my knowledge, from the causes stated.										
22a. SIGNATURE <u>W. S. Bebery M A</u> (Degree or title)					22b. ADDRESS <u>Miller Mo</u>			22c. DATE SIGNED <u>6-25-60</u>		
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE <u>6-22-1960</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Orank Prairie</u>			23d. LOCATION (City, town, or county) (State) <u>S.E. of Miller Mo.</u>				
24. FUNERAL DIRECTOR <u>Ed. Simon</u> ADDRESS <u>Miller Mo.</u>			25. DATE RECD. BY LOCAL REG. <u>6-24-1960</u>		26. REGISTRAR'S SIGNATURE <u>W. L. Foyett</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 me

~~or by~~ \_\_\_\_\_, Student Embalmer No. \_\_\_\_\_

working under my personal supervision.

Student \_\_\_\_\_

Signature of Student Embalmer

Signed E. R. Seimon

Licensed Embalmer No. 3297

P. O. Address Miller 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.