

FRI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

=60-024027

FILED VS. JUN 30 1960 274

274

3052

221

STATE FILE NUMBER

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

1. PLACE OF DEATH		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)	
a. COUNTY <u>Pettis</u>	a. STATE <u>Mo</u>	b. COUNTY <u>Pettis</u>	
b. CITY (if outside corporate limits, give TOWNSHIP only) OR TOWN <u>Sedalia</u>	Length of stay in 1b <u>25 yrs</u>	c. CITY OR TOWN <u>Sedalia</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>910 West 20th</u>	Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (if outside, give location) <u>910 West 20th</u>	Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print)	First <u>Zula</u>	Middle <u>FRANCES</u>	Last <u>Haight</u>	4. DATE OF DEATH	Month <u>June</u>	Day <u>18</u>	Year <u>1960</u>
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5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. Married <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <u>5-22-1888</u>	9. AGE (last birthday) <u>72</u>	IF UNDER 1 YEAR Months _____ Days _____	IF UNDER 24 HR Hours _____ Min. _____
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>School Teacher</u>	10b. KIND OF BUSINESS OR INDUSTRY <u>Schools</u>	11. BIRTHPLACE (City and state or country) <u>Sedalia, Mo</u>	12. CITIZEN OF WHAT COUNTRY <u>U. S. A</u>
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13a. FATHER'S NAME <u>Zalmon Haight</u>	13b. MOTHER'S MAIDEN NAME <u>Priscilla Claburn</u>	14. NAME OF HUSBAND OR WIFE _____
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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 <u>Mrs Theodosia Hampton</u>	Address <u>910 W. 20th Sedalia</u>
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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
IMMEDIATE CAUSE (a)	<u>Coronary Occlusion</u>	
CONDITIONS, IF ANY, WHICH GAVE RISE TO ABOVE CAUSE (a), STATING THE UNDERLYING CAUSE LAST.	DUE TO (b) <u>Arteriosclerosis</u>	
	DUE TO (c)	

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>Patient was found dead in her home.</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
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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.)
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20c. TIME OF INJURY Hour _____ s.m. _____ p.m. _____	Month, Day, Year _____
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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 _____
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21. I attended the deceased from 1/3/52 to 1/26/60 and last saw her alive on 1/26/60
Death occurred at Time unknown m on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) <u>Karl D. Jones MD</u>	22b. ADDRESS <u>101 1/2 S. Ohio Sedalia, Mo.</u>	22c. DATE SIGNED <u>6/21/60</u>
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23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE <u>6-22-60</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Camp Branch</u>	23d. LOCATION (City, town, or county) (State) <u>Pettis Co. Mo.</u>
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24. FUNERAL DIRECTOR <u>McLaughlin Bros</u>	ADDRESS <u>Sedalia</u>	25. DATE RECD. BY LOCAL REG. <u>June 21-1960</u>	26. REGISTRAR'S SIGNATURE <u>Frances Shelby</u>
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DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

REAR 1 C

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 K.P. McCluar

Licensed Embalmer No. 3153

P. O. Address Sedalia

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.