

RI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

=60-024117

LED VS JUN 20 1960

Registration District No. 290 Primary Registration District No. _____ Registrar's No. 79

STATE FILE NUMBER

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

3. NAME OF DECEASED (Type or print) First <u>Dan</u> Middle _____ Last <u>Alexander</u>	4. DATE OF DEATH Month <u>6</u> Day <u>4</u> Year <u>1960</u>
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5. SEX <u>Male</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>10/5/1881</u>	9. AGE (last birthday) <u>78</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>Farming Retired</u>	10b. KIND OF BUSINESS OR INDUSTRY <u>Farm</u>	11. BIRTHPLACE (City and state or country) <u>Crocker, Missouri</u>	12. CITIZEN OF WHAT COUNTRY <u>U. S. A.</u>
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13a. FATHER'S NAME <u>James Alexander</u>	13b. MOTHER'S MAIDEN NAME <u>Elizabeth Willis</u>	14. NAME OF HUSBAND OR WIFE <u>Ollie Alexander</u>
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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>Unknown</u>	17. INFORMANT Address <u>Mrs. Dan Alexander, Dixon, Missouri</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>ASPIRATION PNEUMONIA</u>		<u>4 DAYS</u>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) <u>MULTIPLE CEREBRAL THROMBOSES</u>	<u>YEARS</u>
	DUE TO (c) <u>GENERALIZED ARTERIO SCLEROSIS</u>	<u>YEARS</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 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"/> <u>NONE</u>	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.) <u>NONE</u>
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20c. TIME OF INJURY Hour _____ a.m. _____ p.m. <u>NONE</u>	Month, Day, Year <u>NONE</u>
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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 December 1959 to June 1960 and last saw her/him alive on 2nd June 1960
Death occurred at 12:25 P. m on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) <u>William P. Kelly, M.D.</u>	22b. ADDRESS <u>Box 306, Dixon, Missouri</u>	22c. DATE SIGNED <u>6 June 60</u>
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23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE <u>6/7/1960</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Alder Springs Cemetery</u>	23d. LOCATION (City, town, or county) (State) <u>Miller County, Missouri</u>
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24. FUNERAL DIRECTOR ADDRESS <u>Gilbert Funeral Home, Inc., Dixon, Mo.</u>	25. DATE RECD. BY LOCAL REG. <u>6-7-60</u>	26. REGISTRAR'S SIGNATURE <u>Paula Mae Anderson</u>
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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 Maurice Schierbaum

Licensed Embalmer No. 4505

P. O. Address Dixon, Missouri

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.