

DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-60-025647

FILED VS AUG 9 1960

STATE FILE NUMBER

Registration District No. 1 Primary Registration District No. 3000 Registrar's No. 241

1. PLACE OF DEATH a. COUNTY <u>Adair</u> b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Kirksville</u> Length of stay in 1b <u>36 yrs</u> c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>902 S. Halliburton</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Mo.</u> b. COUNTY <u>Adair</u> c. CITY OR TOWN <u>Kirksville</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> d. STREET ADDRESS (If outside, give location) <u>902 S. Halliburton</u> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>BESSIE</u> Middle <u>C.</u> Last <u>LOUDERBACK</u>			4. DATE OF DEATH Month <u>August</u> Day <u>4</u> Year <u>1960</u>				
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. Married <input checked="" type="checkbox"/> XXXXXXXXXXXX	8. DATE OF BIRTH <u>9/24/92</u>	9. AGE (last birthday) <u>67</u>	IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Homemaker</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>own Home</u>		11. BIRTHPLACE (City and state or country) <u>Macon, Co. Mo.</u>			
12. CITIZEN OF WHAT COUNTRY <u>U S</u>		13a. FATHER'S NAME <u>C. T. Cabeen</u>		13b. MOTHER'S MAIDEN NAME <u>Rhoda Cooper</u>			
14. NAME OF HUSBAND OR WIFE <u>William L.</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>None</u>			
17. INFORMANT <u>Wm. L. Louderback, Kirksville, Mo.</u>		17. INFORMANT Address <u>Kirksville, Mo.</u>					
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>Coronary occlusion</u> DUE TO (b) <u>Arteriosclerotic heart disease</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 <u>1 hr</u> <u>1 year</u>		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I. <u>Diabetes mellitus - cerebral thrombosis</u>					PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input checked="" type="checkbox"/> N <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 <u> </u> a.m. <u> </u> p.m. 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>1955</u> to <u>Aug 4 1960</u> and last saw <u>her</u> alive on <u>Aug 4, 1960</u> Death occurred at <u>8:00 p</u> m on the date stated above, and to the best of my knowledge, from the causes stated.							
22a. SIGNATURE (Degree or title) <u>W. L. Louderback D.O.</u>			22b. ADDRESS <u>Kirksville Mo</u>		22c. DATE SIGNED <u>Aug 5 1960</u>		
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE <u>Aug. 7-60</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Maple Hill</u>		23d. LOCATION (City, town, or county) (Site) <u>Kirksville, Adair, Mo.</u>		
24. FUNERAL DIRECTOR <u>Foster Memorial Home, Kirksville, Mo.</u>		25. DATE RECD. BY LOCAL REG. <u>8-5-60</u>		26. REGISTRAR'S SIGNATURE <u>Dore W. Patton</u>			

DOCUMENT

MEDICAL CERTIFICATE GUTENSOHN

BY AFFIDAVIT OF

M. T. GUTENSOHN, D.O.

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 Nova E. Foster
Nova E. Foster
Licensed Embalmer No. 4742
P. O. Address Kirksville, N

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