...RI DIVISION OF HEALTH – STANDARD CERTIFICATE OF DEATH

...TILED VS AUG 1 2 1960

-60-025728

STATE FILE NUMBER

...NDED

Registration District No. 11 Primary Registration District No. 4024 Registrar's No. 69

1. PLACE OF DEATH
a. COUNTY: BARRY
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN: CASSVILLE
Length of stay in 1b: 7 DAYS
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION: COMMUNITY HOSPITAL
Inside Limits: Yes ☐ No ☐

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: MISSOURI b. COUNTY: BARRY
c. CITY OR TOWN: SELIGMAN
Inside Limits: Yes ☐ No ☒
d. STREET ADDRESS (If outside, give location): EAST OF SELIGMAN, Mo.
Reside on Farm: Yes ☒ No ☐

3. NAME OF DECEASED (Type or print): First ROSA Middle LEE Last AMOS

4. DATE OF DEATH: Month JULY Day 23, Year 1960

5. SEX: FEMALE

6. COLOR OR RACE: WHITE

7. Married ☐ Never Married ☐ Widowed ☒ Divorced ☐

8. DATE OF BIRTH: 9/10/1885

9. AGE (last birthday): 74

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): HOUSEWIFE

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (City and state or country): WEST VIRGINIA

12. CITIZEN OF WHAT COUNTRY: USA

13a. FATHER'S NAME: No RECORD

13b. MOTHER'S MAIDEN NAME: No RECORD

14. NAME OF HUSBAND OR WIFE: HUSBAND DECEASED 1959

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO (If yes, give war or dates of service) NO

16. SOCIAL SECURITY NO.:

17. INFORMANT: RAY AMOS Address: SPRINGFIELD, MISSOURI

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)	Cerebral Vascular Accident	9 days
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b)	Atherosclerosis	Unknown
DUE TO (c)		

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. ☐ Yes ☒ No ☐ Unknown

MEDICAL CERTIFICATION

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT ☐ **SUICIDE** ☐ **HOMICIDE** ☐

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 ☐ NOT WHILE AT WORK ☐

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 July 15, 1960, to July 23, 1960 and last saw her alive on July 23, 1960

Death occurred at 11:00 P m on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title): Carver E. Endsley, DO

22b. ADDRESS: Cassville, Mo.

22c. DATE SIGNED: 8/2/60

23a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL

23b. DATE: JULY 26, 1960

23c. NAME OF CEMETERY OR CREMATORY: ROLLER CEMETERY

23d. LOCATION (City, town, or county) (State): NORTH OF GATEWAY, ARKANSAS

24. FUNERAL DIRECTOR ADDRESS: CALLISON FUNERAL HOME-ROGERS, ARKANSAS

25. DATE RECD. BY LOCAL REG.: Aug 3 - 1960

26. REGISTRAR'S SIGNATURE: Grace Williams

(Licensed Embalmer's Statement on Reverse Side)

BY AFFIDAVIT OF DOCUMENT

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 [signature]

Licensed Embalmer No. 934

P. O. Address Box 470

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