

RI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-60-025825

FILED VS JUL 18 1960

Registration District No. 38 Primary Registration District No. 3006 Registrar's No. 393

STATE FILE NUMBER

1. PLACE OF DEATH a. COUNTY <u>Boone</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Mo.</u> b. COUNTY <u>Dent.</u>			
b. CITY (If outside corporate limits, give TOWNSHIP only) <u>Columbia,</u>		Length of stay in 1b <u>32 days</u>		c. CITY OR TOWN <u>Salem</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>Medical Center</u>			Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location) <u>Route #3</u>		Reside on Farm Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Middle Last <u>IRENE Midyett MORTON</u>				4. DATE OF DEATH Month Day Year <u>7 10 60</u>			
5. SEX <u>Female</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>12-20-28</u>	9. AGE (last birthday) <u>31</u>	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HR Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>NONE</u>		11. BIRTHPLACE (City and state or country) <u>CRAWford County, U.S.A.</u>		12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>
13a. FATHER'S NAME <u>Eseo Elmer Midyett</u>			13b. MOTHER'S MAIDEN NAME <u>Alice Platt.</u>			14. NAME OF HUSBAND OR WIFE <u>Clive MORTON</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, go, or unknown) (If yes, give war or dates of service) <u>NO.</u>			16. SOCIAL SECURITY NO. <u>NONE</u>		17. INFORMANT <u>Hospital Record</u> Address		
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>Cerebral Hemorrhage</u>							
DUE TO (b) <u>Uremia</u>							
DUE TO (c) <u>Acute Renal Failure</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>Clostridia Septicemia</u>							PART III. If deceased was female was there a pregnancy in last 90 days. <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
19. WAS AUTOPSY PERFORMED? YES <input checked="" 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 a.m. p.m. Month, Day, Year							
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>6-2-60</u> to <u>7-10-60</u> and last saw her ^{him} alive on <u>7-10-60</u> Death occurred at <u>10:50 A.M.</u> on the date stated above, and to the best of my knowledge, from the causes stated.							
22a. SIGNATURE (Degree or title) <u>Rev. E. Stuppel M.D.</u>				22b. ADDRESS <u>Mo. U. Med Center</u>		22c. DATE SIGNED <u>7/10/1960</u> (State)	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>		23b. DATE <u>7/11/1960</u>	23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City, town, or county) <u>Salem, Mo</u> (State)		
24. FUNERAL DIRECTOR <u>Lynn Sprinkle</u> ADDRESS <u>Columbia, Mo.</u>		25. DATE RECD. BY LOCAL REG. <u>July 11 1960</u>		26. REGISTRAR'S SIGNATURE <u>Mrs R E Palmer</u>			

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

VS
MAR 2 4 1968

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. 4013

P. O. Address Columbia

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