

JRI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

FILED VS AUG 8 1960

-60-025840

Registration District No. 28 Primary Registration District No. 3006 Registrar's No. 438

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>Callaway</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Columbia</u>	Length of stay in 1b <u>4 years</u>	c. CITY OR TOWN <u>Fulton, Mo.</u>	Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF DECEASED (If NOT in hospital, give location) <u>Rector Nursing Home</u>		d. STREET ADDRESS (If outside, give location) <u>711 Walnut</u>	Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print) First <u>Berdena</u> Middle <u>AFTON</u> Last <u>TRUITT</u>			4. DATE OF DEATH Month <u>aug</u> Day <u>4</u> Year <u>1960</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <u>aug 13 1864</u>	9. AGE (last birthday) <u>94</u>	10. UNDER 1 YEAR IF UNDER 24 HR Months Days 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 <input checked="" type="checkbox"/>	11. BIRTHPLACE (City and state or country) <u>Fulton, Mo.</u>		12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>	
13a. FATHER'S NAME <u>R.H. Nichols</u>		13b. MOTHER'S MAIDEN NAME <u>MARY Nichols</u>		14. NAME OF HUSBAND OR WIFE <u>W T TRUITT</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>Wheeler TRUITT</u> Address <u>203 S. Hwy 54 FULTON, 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>apoplexy, cerebral recurrent</u> DUE TO (b) <u>arteriosclerosis, generalized</u> DUE TO (c) _____ Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.		INTERVAL BETWEEN ONSET AND DEATH
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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 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.)
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 May 1958 to aug. 1960 and last saw her alive on aug. 2, 1960
Death occurred at 11:45 A.M. on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Doctor or title) <u>James M. Baker M.D.</u>		22b. ADDRESS <u>Columbia Mo</u>		22c. DATE SIGNED <u>aug 4 1960</u>
23a. BURIAL, CREMATION, OR OTHER (Specify) <u>Burial</u>	23b. DATE <u>Aug. 7, 1960</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Millersburg Cem</u>	23d. LOCATION (City, town or county) (State) <u>Callaway Co. Mo.</u>	
24. FUNERAL DIRECTOR <u>Maupia Funeral Home, Fulton, Mo.</u>		25. DATE RECD. BY LOCAL REG. <u>Aug 4, 1960</u>	26. REGISTRAR'S SIGNATURE <u>Mrs. R.E. Palmer</u>	

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 Marshall C. Black

Licensed Embalmer No. 471

P. O. Address Fulton, N

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.