

IRI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-60-026262

FILED VS AUG 1 1960

75 Primary Registration District No. 3015 Registrar's No. 84

STATE FILE NUMBER

INDEXED

DOCUMENT

1. PLACE OF DEATH a. COUNTY <u>CLINTON</u> b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>CAMERON</u> Length of stay in lb <u>4 days</u> c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>Cameron Community Hosp.</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>DeKalb</u> c. CITY OR TOWN <u>Osborn</u> Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> d. STREET ADDRESS (If outside, give location) <u>R 70 # 1</u> Reside on Farm Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Frances</u> Middle <u>Minnie</u> Last <u>Rogers</u>			4. DATE OF DEATH Month <u>July</u> Day <u>30</u> Year <u>1960</u>				
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</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>11-3-1898</u>	9. AGE (last birthday) <u>61</u>	IF UNDER 1 YEAR Months <u>0</u> Days <u>0</u> Hours <u>0</u> Min. <u>0</u>		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>at home. Housekeeper</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Same</u>		11. BIRTHPLACE (City and state or country) <u>DeKalb Co Mo</u>			
10c. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>		13a. FATHER'S NAME <u>Theo. L. Guffe</u>		13b. MOTHER'S MAIDEN NAME <u>Mary Kupijack</u>			
14. NAME OF HUSBAND OR WIFE <u>Guy Rogers</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>Guy Rogers</u> Address <u>Osborn 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>ruptured duo canal ulcer</u> DUE TO (b) _____ DUE TO (c) _____ Conditions, if any, which gave rise to above cause (a), stating the underlying cause last: _____					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (e)				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"/>		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 checked="" 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>7-29-60</u> to <u>7-30-60</u> and last saw her/him alive on <u>7-30-60</u> Death occurred at <u>7:50</u> <u>P</u> on the date stated above, and to the best of my knowledge, from the causes stated.							
22a. SIGNATURE (Degree or title) <u>J. K. K... M.D.</u>			22b. ADDRESS <u>Cameron Mo</u>		22c. DATE SIGNED <u>7/31/60</u>		
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE <u>8-1-1960</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Osborn</u>	23d. LOCATION (City, town, or county) <u>Osborn</u> (State) <u>MO</u>				
24. FUNERAL DIRECTOR <u>Poland Funeral Home</u> ADDRESS <u>Cameron</u>		25. DATE RECD. BY LOCAL REG. <u>Aug 1 1960</u>		26. REGISTRAR'S SIGNATURE <u>Francis D Crawford</u>			

BY AFFIDAVIT OF

SEP 6 1960

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 Robert F. Tol
4777

Licensed Embalmer No. _____

P. O. Address Camden

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.