

DEPARTMENT OF HEALTH - STANDARD CERTIFICATE OF DEATH

-60-026316

FILED VS. AUG 2 1960 93 Primary Registration District No. 4153 Registrar's No. 60-49 STATE FILE NUMBER

1. PLACE OF DEATH a. COUNTY <u>Dade</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Dade</u> b. COUNTY <u>Mo</u>				
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Rockwood Mo</u>		Length of stay in 1b <u>3wks</u>		c. CITY OR TOWN <u>So Greenfield Mo</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>Memorial Hospital</u>			Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location) <u>1mi So.</u>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Delana</u> Middle <u>Frances</u> Last <u>French</u>				4. DATE OF DEATH Month <u>July</u> Day <u>19</u> Year <u>1960</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>July 20 1887</u>	9. AGE (last birthday) <u>72</u>	IF UNDER 1 YEAR Months <u>11</u> Days <u>29</u>	IF UNDER 24 HR Hours <u></u> Min. <u></u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>House wife</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>Farming</u>		11. BIRTHPLACE (City and state or country) <u>Dade Co Mo.</u>		12. CITIZEN OF WHAT COUNTRY <u>usa</u>	
13a. FATHER'S NAME <u>W.A. Stapp</u>			13b. MOTHER'S MAIDEN NAME <u>Lucinda Bowels</u>			14. NAME OF HUSBAND OR WIFE <u>John W French</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>D 195-40-6252</u>		17. INFORMANT Address <u>Opal Denney So Greenfield 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>Carcinoma of Stomach</u>							INTERVAL BETWEEN ONSET AND DEATH <u>2 1/2 yrs</u>	
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) _____ 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. <input type="checkbox"/> Yes <input checked="" 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 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>1-11-58</u> to <u>7-14-60</u> and last saw her <u>live</u> on <u>7-14-60</u> Death occurred at <u>6:50p</u> on the date stated above, and to the best of my knowledge, from the causes stated.								
22a. SIGNATURE <u>Lee A Mc Neel Jr MD</u> (Degree or title)				22b. ADDRESS <u>Greenfield, MO.</u>			22c. DATE SIGNED <u>7-22-60</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE <u>July 22 1960</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Pennsboro</u>		23d. LOCATION (City, town, or county) <u>Dade Co Mo.</u>		(State)	
24. FUNERAL DIRECTOR <u>Allison Funeral Home Greenfield Mo.</u> ADDRESS				25. DATE RECD. BY LOCAL REG. <u>7-27-1960</u>		26. REGISTRAR'S SIGNATURE <u>J. C. Canada</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 W. N. Allison

Licensed Embalmer No. 440

P. O. Address Quincy

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.