

JURY DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

FILED VS JUL 19 1960

-60-026325

STATE FILE NUMBER

Registration District No. 096 Primary Registration District No. \_\_\_\_\_ Registrar's No. 48

INDEXED

1. PLACE OF DEATH a. COUNTY <b>Dallas</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Missouri</b> b. COUNTY <b>Dallas</b>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>Buffalo</b>		Length of stay in 1b <b>Life</b>	c. CITY OR TOWN <b>Buffalo</b> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>At Home</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <b>In Town</b> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print) First <b>Sarah</b> Middle <b>Jane</b> Last <b>McDaniel</b>			4. DATE OF DEATH Month <b>July</b> Day <b>3</b> Year <b>1960</b>		
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <b>July 29, 1885</b>	9. AGE (last birthday) <b>74</b>	IF UNDER 1 YEAR Months <b>11</b> Day <b>4</b> Hours <b></b> Min. <b></b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>At Home</b>	11. BIRTHPLACE (City and state or country) <b>Buffalo, Missouri</b>		12. CITIZEN OF WHAT COUNTRY <b>USA</b>
13a. FATHER'S NAME <b>Bouglas Smith</b>		13b. MOTHER'S MAIDEN NAME <b>Maggie Evans</b>		14. NAME OF HUSBAND OR WIFE <b>Bill McDaniel</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b> <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>		17. INFORMANT <b>Bill McDaniel Buffalo, Missouri</b> 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) <b>Bronchial Pneumonia - Terminal</b>			<b>3 day</b>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b)	<b>Fracture of pelvis + humerus</b>	<b>7 wks</b>
	DUE TO (c)	<b>Multiple myeloma</b>	<b>1 yr</b>
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 type="checkbox"/> No <input type="checkbox"/> Unknown

19. WAS AUTOPSY PERFORMED? YES <input 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 30 May 60 to 3 July 60 and last saw her/him alive on 3 July 60  
Death occurred at 5:40 p m on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE <i>A. Gruffen MD</i> (Degree or title)	22b. ADDRESS <b>Buffalo Mo.</b>	22c. DATE SIGNED <b>5 July 60</b>
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23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE <b>July 6, 1960</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Oak Lawn Cemetery</b>	23d. LOCATION (City, town, or county) (State) <b>Buffalo, Missouri</b>
24. FUNERAL DIRECTOR <b>L. B. Jones</b> ADDRESS <b>Buffalo, Missouri</b>	25. DATE RECD. BY LOCAL REG. <b>7/16/60</b>	26. REGISTRAR'S SIGNATURE <i>Mrs Vera Petree</i>	

(Licensed Embalmer's Statement on Reverse Side)

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

*Carl Papp*

Licensed Embalmer No. 3458

P. O. Address Anderson, TN

**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.