

## I DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

FILED VS AUG 15 1960

=60-026415

STATE FILE NUMBER

Registration District No. 115-116 Primary Registration District No. 3020 Registrar's No. 188

1. PLACE OF DEATH a. COUNTY <u>Franklin</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Mo</u> b. COUNTY <u>Franklin</u>			
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Washington</u>		Length of stay in lb <u>26 hrs.</u>		c. CITY OR TOWN <u>Pacific</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (IF NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>St. Francis</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location)		Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Andrew</u> Middle <u>Roland</u> Last <u>Waggoner</u>				4. DATE OF DEATH Month <u>Aug</u> Day <u>6</u> Year <u>1960</u>			
5. SEX <u>m</u>		6. COLOR OR RACE <u>wh.</u>		7. Married <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>		8. DATE OF BIRTH <u>Sept. 8 '59</u>	
9. AGE (last birthday) <u>10</u> Months <u>28</u> Days <u>28</u> Hours <u></u> Min. <u></u>		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (City and state or country) <u>Normandy, Mo</u>	
13a. FATHER'S NAME <u>Albert Waggoner</u>		13b. MOTHER'S MAIDEN NAME <u>Leona Nickelson</u>		14. NAME OF HUSBAND OR WIFE <u>—</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>none</u>		17. INFORMANT <u>Leona Waggoner, Pacific, Mo</u> Address <u></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>Lobar pneumonia</u> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <u></u> DUE TO (c) <u></u>						INTERVAL BETWEEN ONSET AND DEATH <u>3 days</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>Severe Secondary (Nutritional) Anemia</u>						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 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 <u></u> a.m. <u></u> p.m. <u></u> Month, Day, Year <u></u>							
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>Aug 5, 1960</u> to <u>Aug 6, 1960</u> and last saw him alive on <u>Aug. 6, 1960</u> Death occurred at <u>7:30 am</u> on the date stated above, and to the best of my knowledge, from the causes stated.							
22a. SIGNATURE (Degree or title) <u>John B. Ryan MD</u>				22b. ADDRESS <u>Washington Mo</u>		22c. DATE SIGNED <u>8-8-60</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Aug 9, 1960</u>		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY <u>Sunset Memorial</u>		23d. LOCATION (City, town, or county) (State) <u>Pacific Mo.</u>	
24. FUNERAL DIRECTOR <u>Mrs. John L. Thieles</u>		ADDRESS <u>Pacific Mo.</u>		25. DATE RECD. BY LOCAL REG. <u>8/9/60</u>		26. REGISTRAR'S SIGNATURE <u>JE. Hahnemann</u>	

(Licensed Embalmer's Statement on Reverse Side)

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

SEP 20 1960

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed  
or by \_\_\_\_\_, Student Embalmer No. \_\_\_\_\_  
working under my personal supervision.

Student \_\_\_\_\_  
Signature of Student Embalmer

Signed

*Ralph Ottman*

Licensed Embalmer No. *4808*

P. O. Address *Union, N.J.*

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