

# FRI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

FILED VS JUL 18 1960

=60-026660  
STATE FILE NUMBER

Registration District No. 141 Primary Registration District No. 3025 Registrar's No. 109

1. PLACE OF DEATH a. COUNTY <u>Navasota</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Mo.</u> b. COUNTY <u>Garret</u>			
b. CITY (If outside corporate limits, give TOWNSHIP only) <u>West Plains</u>		Length of stay in 1b <u>hrs</u>		c. CITY OR TOWN <u>Dora</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 Hosp</u>			Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location) <input checked="" type="checkbox"/>		Reside on Farm Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <u>Rena</u> Middle <u>Cash</u> Last <u></u>				4. DATE OF DEATH Month <u>6</u> Day <u>30</u> Year <u>60</u>			
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>		8. DATE OF BIRTH <u>8-21-97</u>	9. AGE (last birthday) <u>62</u>	IF UNDER 1 YEAR Months <u></u> Days <u></u>	IF UNDER 24 HR Hours <u></u> Min. <u></u>
10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Nurse</u>			10b. KIND OF BUSINESS OR INDUSTRY <input checked="" type="checkbox"/>		11. BIRTHPLACE (City and state or country) <u>Dora, Mo</u>		12. CITIZEN OF WHAT COUNTRY <u>USA</u>
13a. FATHER'S NAME <u>Ed Wheat</u>			13b. MOTHER'S MAIDEN NAME <u>unt</u>		14. NAME OF HUSBAND OR WIFE <u>R.E. Cash</u>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u></u>			16. SOCIAL SECURITY NO. <u>Yes</u>		17. INFORMANT <u>R.E. Cash, Dora 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>Congestive Heart Failure</u> (b) <u>Pulmonary Edema</u> DUE TO (c) <u>Cardiac Asthma</u> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (c) <u></u>							INTERVAL BETWEEN ONSET AND DEATH (a) <u>5 hrs</u> (b) <u>12 hrs</u> (c) <u>5 yrs</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>Arteriosclerotic heart disease</u>					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 <u></u> a.m. <u></u> p.m. <u></u>	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>May 13, 1960 A.</u> to <u>June 30, 1960</u> and last saw <u>her</u> him alive on <u>June 30, 1960</u> Death occurred at <u>4:57 A.</u> on the date stated above, and to the best of my knowledge, from the causes stated.							
22a. SIGNATURE (Degree or title) <u>Murray T. Pritchard, M.D.</u>				22b. ADDRESS <u>913 W. Main West Plains, Mo.</u>		22c. DATE SIGNED <u>7-6-60</u>	
23a. BURIAL OR CREMATION, REMOVED (Specify)		23b. DATE <u>7-2-60</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Wagon</u>		23d. LOCATION (City, town or county) (State) <u>Dora, Mo</u>		
24. FUNERAL DIRECTOR <u>Roberts West Plains</u> ADDRESS <u></u>			25. DATE RECD. BY LOCAL REG. <u>7-13-60</u>		26. REGISTRAR'S SIGNATURE <u>Beatrice Cook</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 *D. A. Laurent*

Licensed Embalmer No. 347

P. O. Address West Ka

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.