

JRI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-60-026678

FILED VS JUL 18 1960 NDED

Primary Registration District No. 142 3586 Registrar's No. 36

STATE FILE NUMBER

1. PLACE OF DEATH a. COUNTY <i>Howell</i>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Missouri</i> b. COUNTY <i>Howell</i>				
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <i>Mountain View</i>		Length of stay in 1b		c. CITY OR TOWN <i>Mountain View</i>		Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>		
c. FULL NAME OF (IF NOT in hospital, give location) HOSPITAL OR INSTITUTION <i>On Route To Hospital</i>			Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>		d. STREET ADDRESS (If outside, give location) <i>R-2</i>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <i>Steve</i> Middle <i>Allen</i> Last <i>Petty</i>				4. DATE OF DEATH Month <i>July</i> Day <i>3</i> Year <i>1960</i>				
5. SEX <i>Male</i>	6. COLOR OR RACE <i>White</i>	7. Married <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>		8. DATE OF BIRTH <i>12/25/54</i>	9. AGE (last birthday) <i>5</i>	IF UNDER 1 YEAR Months Days	IF UNDER 24 HR Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Child</i>			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (City and state or country) <i>St. Louis, Mo.</i>		12. CITIZEN OF WHAT COUNTRY <i>USA</i>	
13a. FATHER'S NAME <i>Bernie J. Petty</i>			13b. MOTHER'S MAIDEN NAME <i>Betty C. Arnold</i>			14. NAME OF HUSBAND OR WIFE		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <i>no</i>			16. SOCIAL SECURITY NO. <i>none</i>		17. INFORMANT <i>Bernie J. Petty</i> Address <i>Mountain View, Mo.</i>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cerebral Hemorrhage</i> DUE TO (b) <i>Skull Fracture</i> DUE TO (c) <i>Hit by Car while Crossing Highway</i> CONDITIONS, IF ANY, WHICH GAVE RISE TO ABOVE CAUSE (a), STATING THE UNDERLYING CAUSE LAST.							INTERVAL BETWEEN ONSET AND DEATH <i>2 hours</i>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <i>Multiple Fractures</i>					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.) <i>Crossed Highway to get ball</i>					
20c. TIME OF INJURY Hour <i>3:15</i> a.m. <i>pm</i> Month, Day, Year <i>7-4-60</i>	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.) <i>45 Highway # 60</i>		20f. CITY, TOWN, OR LOCATION <i>Mtn. View</i>		COUNTY <i>Howell</i>	STATE <i>Mo.</i>
21. I attended the deceased from _____ to _____ and last saw her alive on _____ Death occurred at <i>5:15 PM</i> on the date stated above and to the best of my knowledge, from the causes stated.								
22a. SIGNATURE (Degree or title) <i>Joe C. Duncan, Coroner</i>				22b. ADDRESS <i>Mtn. View Mo.</i>			22c. DATE SIGNED <i>7-10-60</i>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		23b. DATE <i>7/6/60</i>	23c. NAME OF CEMETERY OR CREMATORY <i>Greenlawn Cemetery</i>		23d. LOCATION (City, town, or county) (State) <i>Mountain View, Mo.</i>			
24. FUNERAL DIRECTOR <i>Duncan Funeral Home Mtn. View, Mo.</i>				25. DATE RECD. BY LOCAL REG. <i>7-14-60</i>		26. REGISTRAR'S SIGNATURE <i>Laura Mitchell</i>		

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  
or by \_\_\_\_\_, Student Embalmer No. \_\_\_\_\_

working under my personal supervision.

Student \_\_\_\_\_

Signature of Student Embalmer

Signed

*Charles D. Part*

Licensed Embalmer No. 5107

P. O. Address Mtn. 2

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.