

JRI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

=60-027393

FILED VS JUL 22 1960

Registration District No. 160 Primary Registration District No. 3029 Registrar's No. 88

STATE FILE NUMBER

INDEXED

1. PLACE OF DEATH a. COUNTY Jefferson				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Mo. b. COUNTY Ste. Francois			
b. CITY (If outside corporate limits, give TOWNSHIP only) Crystal City			Length of stay in 1b	c. CITY OR TOWN Leadington		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) - HOSPITAL OR INSTITUTION 218 Pine Street				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 Irma Middle Lola Last Kennedy				4. DATE OF DEATH Month July Day 11 Year 1960			
5. SEX female	6. COLOR OR RACE white	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>		8. DATE OF BIRTH 6-14-1900	9. AGE (last birthday) 60	IF UNDER 1 YEAR Months 0 Days 0	IF UNDER 24 HR Hours 0 Min. 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (City and state or country) U. S. A.		12. CITIZEN OF WHAT COUNTRY U. S. A.
13a. FATHER'S NAME George Washington House			13b. MOTHER'S MAIDEN NAME Cordelia Wishon			14. NAME OF HUSBAND OR WIFE Dewey Kennedy	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no			16. SOCIAL SECURITY NO. 498-24-0705		17. INFORMANT Margaret Cambron, Crystal City, MO		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) TUBERCULOSIS PULMONARY						INTERVAL BETWEEN ONSET AND DEATH 5 years	
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) PLEURAL EFFUSION						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 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 10 a.m. 00 p.m.	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 Crystal City, Mo.	
21. I attended the deceased from JUNE 20 to JULY 11 and last saw her/him alive on JULY 10-60 Death occurred at _____ m on the date stated above, and to the best of my knowledge, from the causes stated.							
22a. SIGNATURE (Degree or title) Henry Goskit M.D.				22b. ADDRESS 1028 W. Main, Festus, Mo.		22c. DATE SIGNED 7/11/60	
23a. BURIAL, CREMATION, REMOVAL (Specify) removal	23b. DATE 7-14-60	23c. NAME OF CEMETERY OR CREMATORY Parkview Cemetery			23d. LOCATION (City, town, or county) St. Francois Co., Mo.		
24. FUNERAL DIRECTOR Raymond Caldwell, Flat River, Mo.				25. DATE RECD. BY LOCAL REG. 7/12/60		26. REGISTRAR'S SIGNATURE <i>[Signature]</i>	

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

JUL 22 1960

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

Donald Dale Cold

Licensed Embalmer No. *5095*

P. O. Address *Flat Pine*

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