URI DIVISION OF HEALTH – STANDARD CERTIFICATE OF DEATH

-60-027538

STATE FILE NUMBER

FILED VS AUG 9 1960 / 179

Registration District No. 179 Primary Registration District No. 5668 Registrar's No. 102

MENDED

1. PLACE OF DEATH
a. COUNTY Lincoln
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Clark — Length of stay in 1b: 9 Mo.
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION 8 mi. S.W. of Troy MO. — Inside Limits: Yes ☐ No ☒

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Missouri b. COUNTY Lincoln
c. CITY OR TOWN Troy — Inside Limits: Yes ☒ No ☐
d. STREET ADDRESS 1040 West Cherry (If outside, give location) — Reside on Farm: Yes ☐ No ☒

3. NAME OF DECEASED (Type or print) First: HANNAN Middle: JANE Last: KNOX

4. DATE OF DEATH Month Day Year: August 1, 1960

5. SEX: Female
6. COLOR OR RACE: Wh ite
7. Married ☐ Never Married ☐ Widowed ☒ Divorced ☐
8. DATE OF BIRTH: 4/13/1884
9. AGE (last birthday): 76
IF UNDER 1 YEAR: Months 5 Days 18 — IF UNDER 24 HR: Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housework
10b. KIND OF BUSINESS OR INDUSTRY: Housewife
11. BIRTHPLACE (City and state or country): Briscoe MO.
12. CITIZEN OF WHAT COUNTRY: U.S.A.

13a. FATHER'S NAME: Jacob Raney
13b. MOTHER'S MAIDEN NAME: Mary Morris
14. NAME OF HUSBAND OR WIFE: James Knox

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service): None
16. SOCIAL SECURITY NO.: None
17. INFORMANT: Mrs Ernie Weitkamp Address: Wright City

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Exhaustion - hemorrhage — INTERVAL BETWEEN ONSET AND DEATH: 3 weeks
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.
DUE TO (b) Gastric C. A. — 2 years.
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. ☐ Yes ☐ No ☐ Unknown

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐
20a. ACCIDENT ☐ SUICIDE ☐ HOMICIDE ☐
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 ☐ NOT WHILE AT WORK ☐
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 June 18, to August 1, 1960 and last saw her/him alive on Aug 1, 1960
Death occurred at 10.00 P.M. on the date stated above, and to the best of my knowledge from the causes stated.

22a. SIGNATURE H. F. Kelley (Degree or title) D.O. — 22b. ADDRESS Troy Mo — 22c. DATE SIGNED 8-2-60

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE: Aug. 4, 1960
23c. NAME OF CEMETERY OR CREMATORY: Morris Cemetery
23d. LOCATION (City, town, or county) (State): Lincoln County MO.

24. FUNERAL DIRECTOR: D. W. McCoy ADDRESS: Troy Mo.
25. DATE RECD. BY LOCAL REG.: Aug. 2, 1960
26. REGISTRAR'S SIGNATURE: Charlotte Leek

(Licensed Embalmer's Statement on Reverse Side)

DOCUMENT

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. W. McCoy

Licensed Embalmer No. 3586

P. O. Address Troy Mo.

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