

RI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-60-027765

FILED VS JUL 20 1960

STATE FILE NUMBER

Registration District No. 255 Primary Registration District No. 5877 Registrar's No. 18

DED

1. PLACE OF DEATH a. COUNTY <u>Oregon</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Mo.</u> b. COUNTY <u>Oregon</u>				
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Couch, Mo.</u>		Length of stay in 1b <u>11 yrs.</u>		c. CITY OR TOWN <u>Couch, Mo.</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>Rt. # 1,</u>			Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>		d. STREET ADDRESS (If outside, give location) <u>Rt. # 1,</u>		Reside on Farm Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>Sarah Jane Whittenburg</u>				4. DATE OF DEATH Month Day Year <u>6-24-1960</u>				
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <u>10-5-1892</u>	9. AGE (last birthday) <u>67</u>	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HR		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u>		11. BIRTHPLACE (City and state or country) <u>Grandon, Missouri</u>		12. CITIZEN OF WHAT COUNTRY <u>USA</u>		
13a. FATHER'S NAME <u>Walter A. Oakley</u>			13b. MOTHER'S MAIDEN NAME <u>Cornellia Jane Carner</u>		14. NAME OF HUSBAND OR WIFE <u>John Whittenburg (Dec.)</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT Address <u>Hubert Whittenburg-Couch, Mo. Rt. 1</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>Cerebrovascular accident</u>						INTERVAL BETWEEN ONSET AND DEATH <u>19 hrs.</u>		
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) _____ DUE TO (a) <u>Respiratory failure</u>								
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 a.m. p.m. Month, Day, Year								
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.)		20f. CITY, TOWN, OR LOCATION		COUNTY	STATE	
21. I attended the deceased from <u>1955</u> to <u>1960</u> and last saw her/him alive on <u>6-24-60</u> Death occurred at <u>11:25 P.M.</u> on the date stated above, and to the best of my knowledge, from the causes stated.								
22a. SIGNATURE <u>Walker m D</u> (Degree or title)			22b. ADDRESS <u>Mannoth Spring, Ark</u>			22c. DATE SIGNED <u>6-29-60</u>		
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE <u>11-26-1960</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Warm Springs Cemetery</u>		23d. LOCATION (City, town, or county) (State) <u>Warm Springs, Ark.</u>				
24. FUNERAL DIRECTOR <u>McNabb Funeral Home</u>		ADDRESS <u>Pocahontas, Arkansas</u>		25. DATE RECD. BY LOCAL REG. <u>7-14-60</u>	26. REGISTRAR'S SIGNATURE <u>M W C Johnson</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 M. C. McNeil

Licensed Embalmer No. 6806

P. O. Address Parsons, Pa.

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.