MO. DIVISION OF HEALTH – STANDARD CERTIFICATE OF DEATH

FILED VS AUG 9 1960

-60-028037
STATE FILE NUMBER

Registration District No. 316 Primary Registration District No. — Registrar's No. 305

1. PLACE OF DEATH
a. COUNTY: ST FRANCOIS
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN: St. Francois Twp. FARMINGTON -Rural
Length of stay in 1b: 25 das.
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION: MIN. AREA. HOSP
Inside Limits: Yes ☐ No ☒

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Mo.
b. COUNTY: Madison
c. CITY OR TOWN: Fredericktown
Inside Limits: Yes ☒ No ☐
d. STREET ADDRESS (If outside, give location):
Reside on Farm: Yes ☐ No ☒

3. NAME OF DECEASED (Type or print): First DAISY Middle Last LOWE

4. DATE OF DEATH: Month AUGUST Day 2 Year 1960

5. SEX: FEMALE

6. COLOR OR RACE: WHITE

7. Married ☐ Never Married ☐ Widowed ☒ Divorced ☐

8. DATE OF BIRTH: 8/5/1880

9. AGE (last birthday): 79

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): HOUSE WIFE

10b. KIND OF BUSINESS OR INDUSTRY: OWN HOME

11. BIRTHPLACE (City and state or country): COBBEN ILL.

12. CITIZEN OF WHAT COUNTRY: U.S.A.

13a. FATHER'S NAME: WILLIAM HATLEY

13b. MOTHER'S MAIDEN NAME: UNKNOWN

14. NAME OF HUSBAND OR WIFE:

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): NO
(If yes, give war or dates of service):

16. SOCIAL SECURITY NO.: NONE

17. INFORMANT Address: GILBERT SHELTON BALDWIN MO.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:

		INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a)	CARDIAC FAILURE	3 days
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b)	AURICULAR FIBRILLATION	3 days
DUE TO (c)	ARTERIOSCLEROTIC HEART DISEASE	UNKNOWN

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a): FRACTURE OF L. FEMUR

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.): FELL

20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year: 7 8 60

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.): ABOUT HOME

20f. CITY, TOWN, OR LOCATION: FREDERICKTOWN (?) COUNTY: MADISON STATE: MO.

21. I attended the deceased from 7-8-60, to 8-2-60 and last saw her/him alive on 8-2-60

Death occurred at 5 40 pm on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title): Ralph D. Cooper D.O.

22b. ADDRESS: RT 1 FARMINGTON

22c. DATE SIGNED: 8-4-60

23a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL

23b. DATE: 8/5/1960

23c. NAME OF CEMETERY OR CREMATORY: upper alton

23d. LOCATION (City, town, or county) (State): ALTON ILL.

24. FUNERAL DIRECTOR ADDRESS: STREEPER FUNERAL HOME ALTON ILL.

25. DATE RECD. BY LOCAL REG.: Aug 4, 1960

26. REGISTRAR'S SIGNATURE: Esther Rudloff

(Licensed Embalmer's Statement on Reverse Side)

DOCUMENT

BY AFFIDAVIT OF

AUG 10 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_____ Signed_____

Signature of Student Embalmer

Licensed Embalmer No._____

P. O. Address_____

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.