

RI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

=60-029395

Filed U.S. Apr. 26, 1960 355

Registration District No. 355 Primary Registration District No. 6204 Registrar's No. _____

STATE FILE NUMBER

IDED

1. PLACE OF DEATH		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)	
a. COUNTY <u>Texas</u>	Length of stay in 1b	a. STATE <u>Missouri</u>	b. COUNTY <u>Texas</u>
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Summersville</u>		c. CITY OR TOWN <u>Summersville</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>Home</u>	Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <u>Route # 1</u>	Reside on Farm Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>

3. NAME OF DECEASED (Type or print)			4. DATE OF DEATH			
First <u>Harrison</u>	Middle <u>J.</u>	Last <u>Jaber</u>	Month <u>April</u>	Day <u>15,</u>	Year <u>1960</u>	

5. SEX <u>M.</u>	6. COLOR OR RACE <u>W.</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>7/18/92</u>	9. AGE (last birthday) <u>67</u>	IF UNDER 1 YEAR Months _____ Days _____	IF UNDER 24 HR Hours _____ Min. _____
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer</u>	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and state or country) <u>Pulaski Co. Mo.</u>	12. CITIZEN OF WHAT COUNTRY <u>USA</u>
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13a. FATHER'S NAME <u>John Jaber</u>	13b. MOTHER'S MAIDEN NAME <u>Mirah</u>	14. NAME OF HUSBAND OR WIFE
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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>yes</u>	17. INFORMANT <u>H.A. Jabers</u>	Address <u>Route # 1 Summersville Mo</u>
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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)	<u>Coronary Occlusion</u>	
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) <u>Arteriosclerotic heart Disease</u>	
	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
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19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input 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.)
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20c. TIME OF INJURY Hour _____ a.m. _____ p.m. _____	Month, Day, Year
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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	COUNTY	STATE
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21. I attended the deceased from 4--1-60 to 4--15-60 and last saw her alive on 4-12-60
Death occurred at 3:20P m on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE <u>M.C. Walton M.D.</u>	(Degree or title)	22b. ADDRESS <u>Mountain View Missouri</u>	22c. DATE SIGNED <u>4--18-60</u>
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23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE <u>4/18/60</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Arroll Cemetery</u>	23d. LOCATION (City, town, or county) <u>Arroll, Missouri</u>	(State)
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24. FUNERAL DIRECTOR <u>Duncan Funeral Home</u>	ADDRESS <u>Mtn. View, Mo.</u>	25. DATE RECD. BY LOCAL REG. <u>4-27-60</u>	26. REGISTRAR'S SIGNATURE <u>Anna Roberts</u>
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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 Richard A. Norton

Licensed Embalmer No. 5029

P. O. Address Mtn. View, Pa.

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.