

JRI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

FILED VS SEP 13 1960

=60-029472

STATE FILE NUMBER

Registration District No. 1 Primary Registration District No. 3000 Registrar's No. 266

1. PLACE OF DEATH a. COUNTY <u>Adair</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Adair</u>									
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Kirksville</u>		Length of stay in lb <u>9 days</u>		c. CITY OR TOWN <u>Novinger</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>							
c. FULL NAME OF (IF NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>Kirksville Osteopathic Hosp</u>			Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>		d. STREET ADDRESS (If outside, give location) <u>No street address</u>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>						
3. NAME OF DECEASED (Type or print) First <u>Alice</u> Middle <u>Mariah</u> Last <u>Chrisman</u>				4. DATE OF DEATH Month <u>August</u> Day <u>19</u> Year <u>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>11/13/1884</u>		9. AGE (last birthday) <u>77</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>Farm home</u>		11. BIRTHPLACE (City and state or country) <u>Martinstown, Mo.</u>		12. CITIZEN OF WHAT COUNTRY <u>USA</u>					
13a. FATHER'S NAME <u>Woodrow Wilson Clay</u>				13b. MOTHER'S MAIDEN NAME <u>Drusella Jane Richardson</u>				14. NAME OF HUSBAND OR WIFE <u>Enoch A. Chrisman</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>Mrs. Orpha Ledford, Unionville, Mo.</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>Exsanguination</u>										INTERVAL BETWEEN ONSET AND DEATH <u>Unknown</u>			
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.		DUE TO (b) <u>Mediocal release</u>											
		DUE TO (c) <u>Unknown</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 <u>5:15</u> Month, Day, Year <u>Aug 19 1960</u>													
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					
21. I attended the deceased from <u>8-10-60</u> to <u>8-19-60</u> and last saw ^{her} him alive on <u>8-19-60</u> Death occurred at <u>5:15</u> <u>Aug</u> m on the date stated above, and to the best of my knowledge, from the causes stated.													
22a. SIGNATURE (Degree or title) <u>A. J. McVitt</u> <u>MD</u>				22b. ADDRESS <u>R.O.H</u>				22c. DATE SIGNED <u>8-30-60</u>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE <u>Aug. 22, 1960</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Green Castle Cemetery</u>		23d. LOCATION (City, town, or county) <u>Green Castle, Mo.</u>		(State)					
24. FUNERAL DIRECTOR <u>Glenn E. Kent</u> <u>Green City, Mo.</u>				25. DATE RECD. BY LOCAL REG. <u>9-8-1960</u>		26. REGISTRAR'S SIGNATURE <u>Deris W. Patuff</u>							

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

S. J. D E VITO, D. O.

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 Earl W. Kent

Licensed Embalmer No. 4689

P. O. Address Green City,

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