

JRI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

=60-029476

FILED VS SEP 13 1960

STATE FILE NUMBER

Registration District No. 1 Primary Registration District No. 3000 Registrar's No. 261

NDED

| | | | | | | | |
|---|---|---|--|---|--|---|--|
| 1. PLACE OF DEATH a. COUNTY <u>Adair</u> | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Mo.</u> b. COUNTY <u>Adair</u> | | | |
| b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Kirksville</u> | | Length of stay in 1b <u>1 month</u> | | c. CITY OR TOWN <u>Kirksville</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>Grim-Smith</u> | | | Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> | d. STREET ADDRESS (If outside, give location) <u>715 W. Hamilton</u> | | Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) First <u>Roxie</u> Middle <u>Jones</u> Last <u>Guffey</u> | | | | 4. DATE OF DEATH Month <u>9</u> Day <u>3</u> Year <u>60</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>4-13-1900</u> | 9. AGE (last birthday) <u>60</u> | IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u> | IF UNDER 24 HR Hours <u> </u> Min. <u> </u> |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>home</u> | | 10b. KIND OF BUSINESS OR INDUSTRY <u>home</u> | | 11. BIRTHPLACE (City and state or country) <u>Putnam County</u> | | 12. CITIZEN OF WHAT COUNTRY <u>USA</u> | |
| 13a. FATHER'S NAME <u>Grant Jones</u> | | | 13b. MOTHER'S MAIDEN NAME <u>Laura McCulloh</u> | | 14. NAME OF HUSBAND OR WIFE <u>Willie Fern Guffey</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>494-38-4203</u> | 17. INFORMANT Address <u>Mrs. Leo Rennells 712 Shelby Kirksville</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>CARCINOMA, PANCREAS</u> | | | | | | INTERVAL BETWEEN ONSET AND DEATH <u>2 1/2 Mos.</u> | |
| Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) _____ 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 checked="" 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 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>7-23-60</u> to <u>9-3-60</u> and last saw her alive on <u>9-2-60</u> Death occurred at <u>4:00 A.M.</u> on the date stated above, and to the best of my knowledge, from the causes stated. | | | | | | | |
| 22a. SIGNATURE <u>Roxie Jones</u> (Degree or title) | | | | 22b. ADDRESS <u>Kirksville, Mo.</u> | | 22c. DATE SIGNED <u>9-5-60</u> | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | 23b. DATE <u>9-5-1960</u> | 23c. NAME OF CEMETERY OR CREMATORY <u>Maple Hills</u> | | 23d. LOCATION (City, town, or county) <u>Kirksville Mo.</u> | | 23e. STATE <u>Mo.</u> | |
| 24. FUNERAL DIRECTOR <u>Doc Riley Funeral Home Inc. Kirksville</u> <u>W.K. Jackson</u> (Licensed Embalmer's Statement on Reverse Side) | | | 25. DATE RECD. BY LOCAL REG. <u>9-5-1960</u> | | 26. REGISTRAR'S SIGNATURE <u>Dora W. Ratliff</u> | | |

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

NOV 10 1960

SEP 27 1960

J. B. Jones, M.D.

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 Wm K. Jackson

Licensed Embalmer No. 3954

P. O. Address Kirksville

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.