

# RI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

**-60-029510**

FILED VS SEP 1 1960

Registration District No. \_\_\_\_\_ Primary Registration District No. \_\_\_\_\_ Registrar's No. **212**

STATE FILE NUMBER

IDED

<b>1. PLACE OF DEATH</b> a. COUNTY <u>Atchison</u> b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Fairfax mo</u> Length of stay in lb <u>1</u> c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>Fairfax Community Hospital</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>				<b>2. USUAL RESIDENCE</b> (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Atchison</u> c. CITY OR TOWN <u>Rock-Port mo</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> d. STREET ADDRESS (If outside, give location) <u>_____</u> Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>			
<b>3. NAME OF DECEASED</b> (Type or print) First <u>Mary</u> Middle <u>Alise</u> Last <u>Hosfield</u>			<b>4. DATE OF DEATH</b> Month <u>aug</u> Day <u>18</u> Year <u>1960</u>				
<b>5. SEX</b> <u>F</u>	<b>6. COLOR OR RACE</b> <u>W</u>	<b>7. Married</b> <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>	<b>8. DATE OF BIRTH</b> <u>Dec. 13-1880</u>	<b>9. AGE</b> (last birthday) <u>79</u>	IF UNDER 1 YEAR Months <u>9</u> Days <u>6</u> Hours <u>_____</u> Min. <u>_____</u> IF UNDER 24 HR Hours <u>_____</u> Min. <u>_____</u>		
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>house wife</u>		<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <u>_____</u>		<b>11. BIRTHPLACE</b> (City and state or country) <u>Atchison mo</u>			
<b>13a. FATHER'S NAME</b> <u>Richard C. Winter</u>		<b>13b. MOTHER'S MAIDEN NAME</b> <u>Sarah M. Stephenson</u>		<b>14. NAME OF HUSBAND OR WIFE</b> <u>Geo Hosfield (deceased)</u>			
<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) (If yes, give war or dates of service) <u>no</u>		<b>16. SOCIAL SECURITY NO.</b> <u>488-44-9090</u>		<b>17. INFORMANT</b> <u>Mrs. Carrie Purcell</u> Address <u>304 W. 3rd St Maryville mo</u>			
<b>18. CAUSE OF DEATH</b> (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral hemorrhage</u> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <u>arteriosclerotic cardiovascular disease</u> years DUE TO (c) <u>_____</u>					INTERVAL BETWEEN ONSET AND DEATH <u>minutes</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 checked="" type="checkbox"/> No <input type="checkbox"/> Unknown			
<b>19. WAS AUTOPSY PERFORMED?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	<b>20a. ACCIDENT</b> <input type="checkbox"/> <b>SUICIDE</b> <input type="checkbox"/> <b>HOMICIDE</b> <input type="checkbox"/>	<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in PART I or PART II of item 18.)					
<b>20c. TIME OF INJURY</b> Hour _____ a.m. _____ p.m. Month, Day, Year _____		<b>20d. INJURY OCCURRED WHILE AT WORK</b> <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>					
<b>20e. PLACE OF INJURY</b> (e.g., in or about home, farm, factory, street, office bldg., etc.)		<b>20f. CITY, TOWN, OR LOCATION</b>		<b>COUNTY</b> _____ <b>STATE</b> _____			
<b>21. I attended the deceased from</b> <u>8/8/60</u> to <u>8/18/60</u> and last saw her/him alive on <u>8/18/60</u> Death occurred at _____ m on the date stated above, and to the best of my knowledge, from the causes stated.							
<b>22a. SIGNATURE</b> (Degree or title) <u>John M. Wananaker, M.D.</u>			<b>22b. ADDRESS</b> <u>Rock Port, Mo.</u>		<b>22c. DATE SIGNED</b> <u>8/19/60</u>		
<b>23a. BURIAL, CREMATION, REMOVAL</b> (Specify) <u>burial</u>	<b>23b. DATE</b>	<b>23c. NAME OF CEMETERY OR CREMATORY</b> <u>Linden cemetery</u>		<b>23d. LOCATION</b> (City, town, or county) (State) <u>n.w. Rock Port mo</u>			
<b>24. FUNERAL DIRECTOR</b> <u>Bertram Funeral Home</u> ADDRESS <u>Rock Port</u>		<b>25. DATE RECD. BY LOCAL REG.</b> <u>Aug 23, 1960</u>		<b>26. REGISTRAR'S SIGNATURE</b> <u>Therwin H. Schaefer</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 *C. E. Burton*

Licensed Embalmer No. 1964

P. O. Address Rock Point

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.