

# MICHIGAN DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

=60-029537

FILED VS SEP 6 1960

Registration District No. 10 Primary Registration District No. 3002 Registrar's No. 205 STATE FILE NUMBER

<b>1. PLACE OF DEATH</b> a. COUNTY <u>Audrain</u> b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Mexico</u> Length of stay in 1b <u>3 yrs.</u> c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>Audrain 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>Mo.</u> b. COUNTY <u>Audrain</u> c. CITY OR TOWN <u>Mexico</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> d. STREET ADDRESS (If outside, give location) <u>804 N. Wade St.</u> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>			
<b>3. NAME OF DECEASED</b> (Type or print) First <u>ANNA</u> Middle <u>M.</u> Last <u>TRIPP</u>			<b>4. DATE OF DEATH</b> Month <u>August</u> Day <u>30</u> , Year <u>1960</u>				
<b>5. SEX</b> <u>Female</u>	<b>6. COLOR OR RACE</b> <u>White</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. 9, 82</u>	<b>9. AGE (last birthday)</b> <u>77 yrs.</u>	<b>IF UNDER 1 YEAR</b> Months _____ Days _____	<b>IF UNDER 24 HR</b> Hours _____ Min. _____	
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>Housekeeper</u>		<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <u>Own Home</u>		<b>11. BIRTHPLACE</b> (City and state or country) <u>Cole County, Mo.</u>		<b>12. CITIZEN OF WHAT COUNTRY</b> <u>U.S.A.</u>	
<b>13a. FATHER'S NAME</b> <u>Squire Lister</u>			<b>13b. MOTHER'S MAIDEN NAME</b> <u>Sarah Hughes</u>			<b>14. NAME OF HUSBAND OR WIFE</b>	
<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>488-38-0926 D</u>		<b>17. INFORMANT</b> Address <u>Mrs. Anderson Mitchell, Mexico, 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>Coronary Thrombosis</u> DUE TO (b) <u>Coronary Sclerosis</u> DUE TO (c) _____ Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.						INTERVAL BETWEEN ONSET AND DEATH <u>8-17-60</u> <u>?</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>General Arteriosclerosis - Coronary Arteriosclerosis</u>					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 checked="" 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.) <u>X</u>			
<b>20c. TIME OF INJURY</b> Hour _____ P.M. Month, Day, Year _____		<b>20d. INJURY OCCURRED WHILE AT WORK</b> <input type="checkbox"/> <b>NOT WHILE AT WORK</b> <input checked="" type="checkbox"/>					
<b>20e. PLACE OF INJURY</b> (e.g., in or about home, farm, factory, street, office bldg., etc.) <u>X</u>		<b>20f. CITY, TOWN, OR LOCATION</b> <u>X</u>		<b>COUNTY</b> _____ <b>STATE</b> _____			
<b>21. I attended the deceased from</b> <u>8-17-60</u> <b>to</b> <u>8-30-60</u> <b>and last saw her/him alive on</b> <u>8-30-60</u> <b>Death occurred at</b> <u>8-30-60</u> <u>10:30</u> <b>am</b> on the date stated above, and to the best of my knowledge, from the causes stated.							
<b>22a. SIGNATURE</b> (Degree or title) <u>Harry F. O'Brien M.D.</u>				<b>22b. ADDRESS</b> <u>Mexico, Missouri</u>		<b>22c. DATE SIGNED</b> <u>9/3/60</u> (State)	
<b>23a. BURIAL, CREMATION, OR REMOVAL</b> (Specify) <u>Burial</u>		<b>23b. DATE</b> <u>Sept. 2, 60</u>		<b>23c. NAME OF CEMETERY OR CREMATORY</b> <u>Elston</u>		<b>23d. LOCATION</b> (City, town, or county) <u>Elston, Mo.</u>	
<b>24. FUNERAL DIRECTOR</b> ADDRESS <u>Precht-Hueston, Mexico, Mo.</u>				<b>25. DATE RECD. BY LOCAL REG.</b> <u>Sept 1-1960</u>		<b>26. REGISTRAR'S SIGNATURE</b> <u>Blanche Reely</u>	

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

SEP 6 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 \_\_\_\_\_  
Signature of Student Embalmer

Signed

*Ralph L. Houston*

Licensed Embalmer No. 4687

P. O. Address Mexico, Mo.

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.