

JRI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

=60-029646

FILED VS AUG 29 1960

38

Primary Registration District No. 3006

Registrar's No. 474

STATE FILE NUMBER

INDEXED

1. PLACE OF DEATH a. COUNTY <u>Boone</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Mo.</u> b. COUNTY <u>Boone</u>											
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Columbia</u>		Length of stay in 1b <u>9 mos.</u>		c. CITY OR TOWN <u>Columbia</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>Rector Nursing Home</u>			Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location) <u>401 Hickman</u>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>								
3. NAME OF DECEASED (Type or print) First <u>Mattie</u> Middle <u>Slater</u> Last <u>Rice</u>				4. DATE OF DEATH Month <u>Aug.</u> Day <u>22</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>3/5/1871</u>		9. AGE (last birthday) <u>89</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>Housewife</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>Home</u>		11. BIRTHPLACE (City and state or country) <u>Boone County, Mo.</u>			12. CITIZEN OF WHAT COUNTRY <u>USA</u>							
13a. FATHER'S NAME <u>John A. Terrell</u>			13b. MOTHER'S MAIDEN NAME <u>Kathryn Ravenscraft</u>			14. NAME OF HUSBAND OR WIFE <u>Deceased</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>-----</u>		17. INFORMANT Address <u>Mrs. Viola Pugh Columbia, 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>Cerebral Thrombosis</u>										INTERVAL BETWEEN ONSET AND DEATH <u>13 hours</u>					
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.		DUE TO (b) <u>Arteriosclerosis</u>			? years										
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		
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>    </u> a.m. <u>    </u> p.m. <u>    </u>		Month, Day, Year <u>    </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>August 19, 1960</u> to <u>August 22, 1960</u> and last saw her alive on <u>August 22, 1960</u> Death occurred at <u>11:24 P</u> m on the date stated above, and to the best of my knowledge, from the causes stated.															
22a. SIGNATURE (Degree or title) <u>B.A. Masonville, II, M.D.</u>					22b. ADDRESS <u>1504 East Broadway</u>					22c. DATE SIGNED <u>8/23/60</u>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE <u>Aug 25/1960</u>		23c. NAME OF CEMETERY OR CREMATORY <u>New Providence Cemetery</u>			23d. LOCATION (City, town, or county) (State) <u>Boone County, Mo.</u>								
24. FUNERAL DIRECTOR ADDRESS <u>Lyman Sprinkle Columbia, Mo.</u>					25. DATE RECD. BY LOCAL REG. <u>Aug. 24, 1960</u>		26. REGISTRAR'S SIGNATURE <u>Mrs. R.E. Palmer</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

*Lyman H. Sprunt*

Licensed Embalmer No. 4013

P. O. Address Columbia

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.