

# URI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-60-029755

SEP 12 1960 042

Registration District No. \_\_\_\_\_ Primary Registration District No. \_\_\_\_\_ Registrar's No. 926

STATE FILE NUMBER

ENDED

1. PLACE OF DEATH				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)			
a. COUNTY <i>Buchanan</i>		b. CITY (If outside corporate limits, give TOWNSHIP only) <i>Tremont Twp.</i>		a. STATE <i>Mo</i>		b. COUNTY <i>Buchanan</i>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <i>6 mi. N.W. of Gower, Mo.</i>		Length of stay in 1b <i>84 yrs.</i>		c. CITY OR TOWN <i>Agency, Mo.</i>		Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
d. STREET ADDRESS <i>6 mi. N.W. of Gower, Mo.</i>		Yes <input type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location)		Reside on Farm Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print)				4. DATE OF DEATH			
First <i>Elmer</i>		Middle <i>Eli</i>		Last <i>Deakins</i>		Month Day Year <i>August 25 1960</i>	
5. SEX <i>Male</i>	6. COLOR OR RACE <i>White</i>	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <i>6/26/1876</i>	9. AGE (last birthday) <i>84</i>	IF UNDER 1 YEAR Months Days	IF UNDER 24 HR Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Farmer</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Farming</i>		11. BIRTHPLACE (City and state or country) <i>Frazier, Mo.</i>		12. CITIZEN OF WHAT COUNTRY <i>U.S.A.</i>	
13a. FATHER'S NAME <i>Richard Deakins</i>		13b. MOTHER'S MAIDEN NAME <i>Mary Giddens</i>		14. NAME OF HUSBAND OR WIFE <i>Emma Deakins</i>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <i>No</i>		16. SOCIAL SECURITY NO. <i>486-44-5601</i>		17. INFORMANT <i>Mrs R.C. McCoy - Agency, Mo.</i>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY:						INTERVAL BETWEEN ONSET AND DEATH	
IMMEDIATE CAUSE (a) <i>Cellulitis Left leg</i>						<i>6 weeks</i>	
DUE TO (b) <i>Arteriosclerotic gangrene L. foot</i>						<i>8 weeks</i>	
DUE TO (c) <i>Arteriosclerotic Generalized</i>							
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 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 <i>8-9-58</i> to <i>8-25-60</i> and last saw her alive on <i>8-21-60</i>				Death occurred at <i>11 PM</i> on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree or title) <i>Irwin Rosenthal M.D.</i>				22b. ADDRESS <i>St Joseph Mo</i>		22c. DATE SIGNED <i>9-1-60.</i>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		23b. DATE <i>Aug 28, 1960</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Frazier</i>		23d. LOCATION (City, town, or county) (State) <i>Agency Mo, Buchanan, MO.</i>	
24. FUNERAL DIRECTOR <i>Clarence E. Hinson</i>		ADDRESS <i>Mo</i>		25. DATE RECD. BY LOCAL REG. <i>Sept 2, 1960</i>		26. REGISTRAR'S SIGNATURE <i>Mrs. Charles Hoodell</i>	

DOCUMENT

L.I. Rosenthal, M.D. ILLINOIS 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 Clarence E. Hipson, Student Embalmer No. 498

working under my personal supervision.

Student Clarence E. Hipson  
Signature of Student Embalmer

Signed Donald W. Hawks

Licensed Embalmer No. 4528

P. O. Address Smithville, Va

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.