

RI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

=60-030200

FILED VS AUG 22 1960

Registration District No. 128 Primary Registration District No. 2000 Registrar's No. 859

STATE FILE NUMBER

1. PLACE OF DEATH a. COUNTY <u>Greene</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> COUNTY <u>Webster</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Springfield</u>		c. CITY OR TOWN <u>Niangra</u>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>Springfield Baptist Hosp #</u>		d. STREET ADDRESS (If outside, give location) <u>Route #1</u>	

3. NAME OF DECEASED (Type or print) First <u>Lee</u> Middle <u>Cain</u> Last <u>Cain</u>			4. DATE OF DEATH Month <u>Aug.</u> Day <u>11</u> Year <u>1960</u>		
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5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <u>6-8-1885</u>	9. AGE (last birthday) <u>75</u>	IF UNDER 1 YEAR Months _____ Days _____	IF UNDER 24 HR Hours _____ Min. _____
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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>Webster County, Mo</u>	12. CITIZEN OF WHAT COUNTRY <u>U S A</u>
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13a. FATHER'S NAME <u>Jackson West</u>	13b. MOTHER'S MAIDEN NAME <u>Nancy Kilburn</u>	14. NAME OF HUSBAND OR WIFE <u>William Allen Cain</u>
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>no none</u>	16. SOCIAL SECURITY NO.	17. INFORMANT <u>William Allen Cain, Niangra, Mo.</u>
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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 <u>24 hrs</u>
IMMEDIATE CAUSE (a) <u>Acute pancreatitis</u>		
DUE TO (b) <u>Chronic cholecystitis with cholelithiasis - 12 yrs</u>		
DUE TO (c) _____		

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>Cholecystectomy & Cholecystectomy 8-9-60</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
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19. WAS AUTOPSY PERFORMED? YES <input checked="" 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.)
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20c. TIME OF INJURY Hour _____ a.m. _____ p.m.	Month, Day, Year _____
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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 _____
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21. I attended the deceased from 8-8-60 to 8-11-60 and last saw her ^{her} alive on 8-11-60
Death occurred at 4:30 p.m. on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) <u>Nesbly MD</u>	22b. ADDRESS <u>Springfield Mo</u>	22c. DATE SIGNED <u>8-12-60</u>
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23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE <u>8-14-1960</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Good Spring</u>	23d. LOCATION (City, town, or county) (State) <u>Stratford Mo</u>
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24. FUNERAL DIRECTOR <u>Rex Rainey, Springfield, Mo.</u>	25. DATE RECD. BY LOCAL REG. <u>8-16-60</u>	26. REGISTRAR'S SIGNATURE <u>Effie E. Melton</u>
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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 *Joe Mason*

Licensed Embalmer No. 456
P. O. Address *Springfield*

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to do so 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.