URI DIVISION OF HEALTH – STANDARD CERTIFICATE OF DEATH

FILED VS AUG 22 1960

=60-030366
STATE FILE NUMBER

ENDED

Registration District No. 141 Primary Registration District No. 3025 Registrar's No. 122

1. PLACE OF DEATH
a. COUNTY Howell
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN West Plains, mo.
Length of stay in 1b: 9 yrs?
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Mask Rest Home
Inside Limits: Yes ☒ No ☐

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Mo. b. COUNTY Howell
c. CITY OR TOWN West Plains, Mo.
Inside Limits: Yes ☒ No ☐
d. STREET ADDRESS (If outside, give location) S. Hill St.
Reside on Farm: Yes ☐ No ☒

3. NAME OF DECEASED (Type or print): First David Middle Alla Last
4. DATE OF DEATH: Month 7- Day 26- Year 1960

5. SEX: M
6. COLOR OR RACE: wht.
7. Married ☐ Never Married ☐ Widowed ☐ unk Divorced ☐
8. DATE OF BIRTH: unk
9. AGE (last birthday): 80 yrs?
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): unk
10b. KIND OF BUSINESS OR INDUSTRY: unk
11. BIRTHPLACE (City and state or country): unk
12. CITIZEN OF WHAT COUNTRY: U. S.A.

13a. FATHER'S NAME: unk.
13b. MOTHER'S MAIDEN NAME: unk.
14. NAME OF HUSBAND OR WIFE: unk.

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service): unk.
16. SOCIAL SECURITY NO.: unk.
17. INFORMANT Address: Dollie Mask, West Plains, Mo.

MEDICAL CERTIFICATION

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)	Cerebral Thrombosis	5 hrs
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b)	Malignant Hypertension	4 yrs
DUE TO (c)	Arteriosclerosis	10 yrs

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a): Uremia

PART III. If deceased was female was there a pregnancy in last 90 days. ☐ Yes ☒ N- ☐ Unknown

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒
20a. ACCIDENT ☐ SUICIDE ☐ HOMICIDE ☐
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 ☐ NOT WHILE AT WORK ☐
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 7-26-60 to and last saw him alive on 7-26-1960
Death occurred at XX approx. 10:00A m on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title): Murray T. Pritchard MD.
22b. ADDRESS: 913 W. Main; West Plains, Mo
22c. DATE SIGNED: 8-8-1960

23a. BURIAL, CREMATION, REMOVAL (Specify): B
23b. DATE: 7-28-1960
23c. NAME OF CEMETERY OR CREMATORY: Oak Lawn Cemetery
23d. LOCATION (City, town, or county) (State): West Plains, Mo.

24. FUNERAL DIRECTOR ADDRESS: Robertson's, West Plains, Mo.
25. DATE RECD. BY LOCAL REG.: 8-16-60
26. REGISTRAR'S SIGNATURE: Beatrice Cook

BY AFFIDAVIT OF — DOCUMENT

(Licensed Embalmer's Statement on Reverse Side)

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed b

or by _____ Student Embalmer No. _____

working under my personal supervision.

Student _____ Signed _____

Signature of Student Embalmer

Licensed Embalmer No. 454

P. O. Address _____

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