

DEPARTMENT OF HEALTH - STANDARD CERTIFICATE OF DEATH

-60-030369

FILED VS SEP 6 1960

Registration District No. 141 Primary Registration District No. 3025 Registrar's No. 131

STATE FILE NUMBER

1. PLACE OF DEATH a. COUNTY <u>Howell</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Mo</u> b. COUNTY <u>Howell</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) <u>West Plains</u>		Length of stay in 1b <u>1hr</u>	c. CITY OR TOWN <u>West Plains</u> Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>Morganas Hosp</u>		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <u>Rebo Rte</u> Reside on Farm Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Middle Last <u>Bonnie Ruth Truman</u>			4. DATE OF DEATH Month Day Year <u>8/16-60</u>
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</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>5/4-35</u>
9. AGE (last birthday) <u>25</u>		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) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>	11. BIRTHPLACE (City and state or country) <u>Chapel Hill, Mo</u>
12. CITIZEN OF WHAT COUNTRY <u>USA</u>		13a. FATHER'S NAME <u>Clarence Warren</u>	
13b. MOTHER'S MAIDEN NAME <u>Helen Patton</u>		13c. NAME OF HUSBAND OR WIFE <u>Ray Truman</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, No, or unknown)		16. SOCIAL SECURITY NO. <u>Yes</u>	
17. INFORMANT <u>Ray Truman, St Louis, 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>CARDIAC ARREST</u> DUE TO (b) <u>CONVULSION DUE TO FEVER</u> DUE TO (c) <u>STREPTOCOCCAL SORE THROAT</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>NONE</u>	
INTERVAL BETWEEN ONSET AND DEATH <u>MIN</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	
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 a.m. p.m.		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>8-15-60</u> to <u>8-16-60</u> and last saw her <u>alive</u> on <u>8-16-60</u> Death occurred at <u>1:10 p.m.</u> on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Do not sign if physician) <u>Robert W. Wilcox, M.D.</u>		22b. ADDRESS <u>West Plains, Mo.</u>	
22c. DATE SIGNED <u>8-30-60</u>		23a. BURIAL, CREMATION, REMOVAL (Specify) <u>8/19-60</u>	
23b. NAME OF CEMETERY OR CREMATORY <u>Howell Memorial Cemetery, Mo</u>		23c. LOCATION (City, town, or county) (State)	
24. FUNERAL DIRECTOR <u>Robertson West Plains Mo</u>		25. DATE RECD. BY LOCAL REG. <u>9-2-60</u>	
26. REGISTRAR'S SIGNATURE <u>Beatrice Cook</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 _____

D. A. Roberts

Licensed Embalmer No. 343

P. O. Address West

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