

FRI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-60-030372

STATE FILE NUMBER

FILED VS 408 22 1960 14/ Primary Registration District No. 3025 Registrar's No. 124

1. PLACE OF DEATH a. COUNTY <i>Howell</i>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Mo.</i> b. COUNTY <i>Howell</i>					
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <i>West Plains,</i>		Length of stay in 1b <i>yrs.</i>		c. CITY OR TOWN <i>West Plains, Mo.</i>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>			
c. FULL NAME OF (IF NOT in hospital, give location) HOSPITAL OR INSTITUTION <i>1028 N. Howell</i>			Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location) <i>1028 N. Howell</i>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First <i>Harry</i> Middle <i>Kingston</i> Last <i>Mahan</i>				4. DATE OF DEATH Month <i>8-3-</i> Day <i>1960</i> Year					
5. SEX <i>M</i>	6. COLOR OR RACE <i>Wht</i>	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <i>1-3-1899</i>	9. AGE (last birthday) <i>61 yrs.</i>	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HR			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>retired oil field worker</i>			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (City and state or country) <i>Pottersville, Mo.</i>		12. CITIZEN OF WHAT COUNTRY <i>U. S. A.</i>		
13a. FATHER'S NAME <i>Isaac Mahan</i>			13b. MOTHER'S MAIDEN NAME <i>Amanda Roberts</i>			14. NAME OF HUSBAND OR WIFE <i>unk</i>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <i>????</i>		16. SOCIAL SECURITY NO. <i>435-07-6507</i>		17. INFORMANT Address <i>Chancey Mahan, West Plains, Mo.</i>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Conjunctive Heart Failure 3 days</i> DUE TO (b) <i>Arteriosclerotic Heart Dis</i> DUE TO (c) Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.						INTERVAL BETWEEN ONSET AND DEATH			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I. <i>Coronary Artery Disease Arteriosclerosis</i>						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 _____ 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>7-18-60</i> to <i>8-2-60</i> and last saw him alive on <i>8-2-60</i> Death occurred at <i>3:45 P.</i> m on the date stated above, and to the best of my knowledge, from the causes stated.									
22a. SIGNATURE (Deed or 11/2) <i>Jack N. Wiley</i>				22b. ADDRESS <i>West Plains, Mo.</i>				22c. DATE SIGNED <i>8-9-60</i>	
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE <i>8-5-1960</i>	23c. NAME OF CEMETERY OR CREMATORY <i>Oak Lawn Cemetery</i>		23d. LOCATION (City, town, or county) <i>West Plains, Mo.</i>		(State)		
24. FUNERAL DIRECTOR <i>Robertson's</i>			ADDRESS <i>West Plains, Mo.</i>		25. DATE RECD. BY LOCAL REG. <i>8-16-60</i>		26. REGISTRAR'S SIGNATURE <i>Beatrice Cook</i>		

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 \_\_\_\_\_, Student Embalmer No. \_\_\_\_\_  
or by \_\_\_\_\_, Student Embalmer No. \_\_\_\_\_  
working under my personal supervision.

Student \_\_\_\_\_  
Signature of Student Embalmer

Signed *Robert A. Mayo*

Licensed Embalmer No. 4547

P. O. Address West Plains

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.