

RI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-60-031156

FILED VS SEP 7 1960

Registration District No. 170 Primary Registration District No. 3033 Registrar's No. 130

STATE FILE NUMBER

1. PLACE OF DEATH a. COUNTY <b>LACLEDE</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Mo</b> b. COUNTY <b>LACLEDE</b>									
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>LEBANON</b>		Length of stay in 1b <b>20 YRS.</b>		c. CITY OR TOWN <b>LEBANON</b>		Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>							
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>LOUISE G. WALLACE</b>			Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location) <b>RURAL RT # 2</b>		Reside on Farm Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>						
3. NAME OF DECEASED (Type or print) First <b>ROSA</b> Middle <b>ELIZABETH</b> Last <b>REED</b>				4. DATE OF DEATH Month <b>AUG</b> Day <b>27</b> Year <b>1960</b>									
5. SEX <b>FEMALE</b>		6. COLOR OR RACE <b>WHITE</b>		7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>		8. DATE OF BIRTH <b>5-10-1878</b>		9. AGE (last birthday) <b>82</b>		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HR Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOUSEWIFE</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>NONE</b>		11. BIRTHPLACE (City and state or country) <b>DALLAS Co, MO.</b>		12. CITIZEN OF WHAT COUNTRY <b>U.S.A.</b>					
13a. FATHER'S NAME <b>FORD MUSTAIN</b>				13b. MOTHER'S MAIDEN NAME <b>EMMALINE RAMBO</b>				14. NAME OF HUSBAND OR WIFE <b>DECEASED</b>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>NO</b>		16. SOCIAL SECURITY NO. <b>NONE</b>		17. INFORMANT <b>J.D. REED, Lebanon, Mo.</b>				Address					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Generalized Arteriosclerosis</b> DUE TO (b) <b>Senility + Helpless</b> DUE TO (c) _____ Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.										INTERVAL BETWEEN ONSET AND DEATH <b>2 mo.</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <b>Diabetes Mellitus</b>								PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input checked="" 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 <b>Dec. 1950</b> to <b>Aug. 1960</b> and last saw her him alive on <b>26 Aug 60</b> . Death occurred at <b>4:30 A.M.</b> on the date stated above, and to the best of my knowledge, from the causes stated.													
22a. SIGNATURE (Degree or title) <b>Paul A. Jenkins M.D.</b>				22b. ADDRESS <b>KNIGHT BLDG Lebanon, Mo</b>				22c. DATE SIGNED <b>29 Aug 1960</b>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		23b. DATE <b>8-29-60</b>		23c. NAME OF CEMETERY OR CREMATORY <b>PLEASANT HILL</b>		23d. LOCATION (City, town, or county) (State) <b>DALLAS Co, MO</b>							
24. FUNERAL DIRECTOR <b>D. Abdel</b>				ADDRESS <b>LEBANON, Mo.</b>		25. DATE RECD. BY LOCAL REG. <b>8-29-1960</b>		26. REGISTRAR'S SIGNATURE <b>Hella E. Hays</b>					

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 \_\_\_\_\_

Licensed Embalmer No. 4734

P. O. Address Spfld, Mo

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.