

MICHIGAN DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-60-031164

FILED VS AUG 23 1960

Registration District No. 170 Primary Registration District No. _____ Registrar's No. 119

STATE FILE NUMBER

1. PLACE OF DEATH a. COUNTY <u>Laclede</u> b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Franklin Twp.</u> Length of stay in lb <u>15 yrs.</u> c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>Oakland Star Rt.</u> Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) STATE <u>Missouri</u> b. COUNTY <u>Laclede</u> c. CITY OR TOWN <u>Lebanon, Rural</u> Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> d. STREET ADDRESS (If outside, give location) <u>Oakland Star Route</u> Reside on Farm Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>															
3. NAME OF DECEASED (Type or print) First <u>Elah</u> Middle <u>Ethel</u> Last <u>Jodd</u>				4. DATE OF DEATH Month <u>August</u> Day <u>13</u> Year <u>1960</u>															
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>10/14/1891</u>		9. AGE (last birthday) <u>68</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>-</u>				11. BIRTHPLACE (City and state or country) <u>Stoutland, Mo. U. S. A.</u>				12. CITIZEN OF WHAT COUNTRY <u>U. S. A.</u>							
13a. FATHER'S NAME <u>Robert Harrill</u>				13b. MOTHER'S MAIDEN NAME <u>Samantha Davis</u>				14. NAME OF HUSBAND OR WIFE <u>W. A. Jodd</u>											
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>no</u>				16. SOCIAL SECURITY NO. <u>566-14-1921</u>				17. INFORMANT <u>W. A. Jodd</u> Address <u>Oakland Star Rt.</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>Carcinoma of the Stomach</u> DUE TO (b) _____ DUE TO (c) _____ Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.										INTERVAL BETWEEN ONSET AND DEATH <u>4 mos.</u>									
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)								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 <u>5-18-56</u> to <u>7-10-60</u> and last saw her ^{her} alive on <u>7-10-60</u> Death occurred at <u>5:30</u> P.m on the date stated above, and to the best of my knowledge, from the causes stated.																			
22a. SIGNATURE (Degree or title) <u>B B Hurst, M.D.</u>						22b. ADDRESS <u>Lebanon, Mo.</u>				22c. DATE SIGNED <u>8-15-60</u>									
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE <u>8/16/1960</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Mt Rose Cemetery</u>				23d. LOCATION (City, town, or county) (State) <u>Lebanon, Mo.</u>											
24. FUNERAL DIRECTOR <u>Dorsey Howe</u> ADDRESS <u>Lebanon, Mo.</u>						25. DATE RECD. BY LOCAL REG. <u>8-16-1960</u>		26. REGISTRAR'S SIGNATURE <u>Albella L. Day</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 Dorsey M. Hou

Licensed Embalmer No. 422

P. O. Address Lebano

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.