URI DIVISION OF HEALTH – STANDARD CERTIFICATE OF DEATH

-60-031239

STATE FILE NUMBER

FILED VS AUG 22 1960

Registration District No. 184 Primary Registration District No. 3038 Registrar's No. 96

NDED

1. PLACE OF DEATH
a. COUNTY Linn
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Brookfield
Length of stay in 1b: 4 weeks
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Pershing Memorial Hosp.
Inside Limits: Yes [X] No [ ]

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Missouri
b. COUNTY Linn
c. CITY OR TOWN Laclede
Inside Limits: Yes [X] No [ ]
d. STREET ADDRESS (If outside, give location)
Reside on Farm: Yes [ ] No [X]

3. NAME OF DECEASED (Type or print) First William Middle Sheridan Last Savage

4. DATE OF DEATH Month August Day 12 Year 1960

5. SEX M
6. COLOR OR RACE W
7. Married [ ] Never Married [ ] Widowed [X] Divorced [ ]
8. DATE OF BIRTH 10-27-1878
9. AGE (last birthday) 81
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) Real Estate Agent, ret.
10b. KIND OF BUSINESS OR INDUSTRY Real Estate
11. BIRTHPLACE (City and state or country) Princeton, Illinois
12. CITIZEN OF WHAT COUNTRY USA

13a. FATHER'S NAME Unavailable
13b. MOTHER'S MAIDEN NAME Unavailable
14. NAME OF HUSBAND OR WIFE Georgia Carothers

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT Mrs. Paul Morrow, Address Laclede, 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)	Acute renal failure	48 hrs.
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b)	Chronic glomerulonephritis.	5 years
DUE TO (c)		

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)
Congestive heart failure 15 years.

PART III. If deceased was female was there a pregnancy in last 90 days. [ ] Yes [ ] No [ ] Unknown

19. WAS AUTOPSY PERFORMED? YES [ ] NO [X]
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 July 2, 1960, to August 12, 1960 and last saw her/him alive on August 12, 1960
Death occurred at 6:30 a.m. on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE DR. R. L. Ryals (Degree or title) R. L. Ryals D.O.
22b. ADDRESS 211 Linn Street Brookfield, Missouri
22c. DATE SIGNED 8-13-60

23a. BURIAL, CREMATION, REMOVAL (Specify) Burial
23b. DATE Aug. 14, 1960
23c. NAME OF CEMETERY OR CREMATORY Laclede Cemetery
23d. LOCATION (City, town, or county) Laclede, Mo. (State)

24. FUNERAL DIRECTOR Wright Funeral Home
ADDRESS Laclede, Mo.
25. DATE RECD. BY LOCAL REG. 8-15-60
26. REGISTRAR'S SIGNATURE Kathaline Johnson Dep.

(Licensed Embalmer's Statement on Reverse Side)

DOCUMENT

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_____ Signed Harold B. Wright

Signature of Student Embalmer

Licensed Embalmer No. 3718

P. O. Address Brookfield

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