

JRI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

FILED VS AUG 24 1960

-60-031251

INDEXED

Registration District No. 385 Primary Registration District No. 3039 Registrar's No. 140

STATE FILE NUMBER

1. PLACE OF DEATH a. COUNTY <u>LINN</u>			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Mo</u> b. COUNTY <u>LINN</u>		
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Marceline Mo</u>		Length of stay in 1b	c. CITY OR TOWN <u>MARCELINE</u>		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>St. Francis Hosp</u>		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <u>223 W Ritchie</u>		Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <u>JEANNE</u> Middle <u>Lucile</u> Last <u>Stanley</u>			4. DATE OF DEATH Month <u>8</u> Day <u>11</u> Year <u>60</u>		
5. SEX <u>Female</u>	6. COLOR OR RACE <u>Anglo Saxon</u>	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <u>8/11/60</u>	9. AGE (last birthday) IF UNDER 1 YEAR Months <u>4</u> Days <u>4</u>	IF UNDER 24 HR Hours <u>4</u> Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (City and state or country) <u>MARCELINE MO</u>	12. CITIZEN OF WHAT COUNTRY <u>USA</u>
13a. FATHER'S NAME <u>T.C. Stanley</u>		13b. MOTHER'S MAIDEN NAME <u>Elizabeth ANNE Meissen</u>		14. NAME OF HUSBAND OR WIFE	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	17. INFORMANT <u>J.P. Stanley</u> 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) <u>Anoxia</u>					INTERVAL BETWEEN ONSET AND DEATH <u>4 Hours</u>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <u>Diaphragmatic hernia and Esotropia with</u>					
DUE TO (c) <u>Hydrocephalus</u>					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>Liver, HEART, Part of Rt. Lung were on outside of Body and were of a large size. Hemorrhage.</u>				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 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 <u>11</u> Month, Day, Year <u>8-11-60</u>	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>8-11-60</u> to <u>8-11-60</u> and last saw her <u>alive</u> on <u>8-11-60</u> Death occurred at <u>9:00 P.</u> on the date stated above, and to the best of my knowledge, from the causes stated.					
22a. SIGNATURE <u>Brookie Owens</u> (Degree or title)			22b. ADDRESS <u>121 N. KANSAS AVE MARCELINE MO.</u>		22c. DATE SIGNED <u>8-12-60</u>
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY <u>St Donaventure</u>	23d. LOCATION (City, town, or county) <u>MARCELINE MO</u>	(State)	
24. FUNERAL DIRECTOR <u>Muller, Tillotson</u> ADDRESS		25. DATE RECD. BY LOCAL REG. <u>8-12-60</u>	26. REGISTRAR'S SIGNATURE <u>Brookie Owens</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 L K Tellatou

Licensed Embalmer No. 4508

P. O. Address Marceline M

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.