

FEDERAL DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-60-031386

FILED VS AUG 30 1960

Registration District No. 211 Primary Registration District No. 4324 Registrar's No. 25-60 STATE FILE NUMBER

1. PLACE OF DEATH a. COUNTY <u>MILLER</u> b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Tuscumbia</u> Length of stay in 1b <u>8 weeks</u> c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>Humphreys-Hospital</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MISSOURI</u> b. COUNTY <u>MILLER</u> c. CITY OR TOWN <u>KAISER-</u> Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> d. STREET ADDRESS (If outside, give location) <u>2mi - E - Krewit-Station</u> Reside on Farm Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First Middle Last <u>SAM - RANKIN TANNHILL</u>			4. DATE OF DEATH Month Day Year <u>Aug - 25 1960</u>		
5. SEX <u>MALE</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>16 April 1902</u>	9. AGE (last birthday) 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>LABORER -</u>
10b. KIND OF BUSINESS OR INDUSTRY <u>Odd. Jobs</u>		11. BIRTHPLACE (City and state or country) <u>Webster-Co Mo</u>		12. CITIZEN OF WHAT COUNTRY <u>USA</u>	
13a. FATHER'S NAME <u>ALVIN-TANNHILL</u>		13b. MOTHER'S MAIDEN NAME <u>MARY-QUICK</u>		14. NAME OF HUSBAND OR WIFE <u>DELLA-TANNHILL</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>NO NONE</u>		16. SOCIAL SECURITY NO. <u>NONE</u>		17. INFORMANT Address <u>DELLA-TANNHILL - KAISER, MO</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>Myocardial Infarction - Hemorrhage</u> DUE TO (b) <u>Generalized arteriosclerosis with arteriosclerotic</u> DUE TO (c) <u>Heart disease, General Arterial Thromboses.</u> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.					INTERVAL BETWEEN ONSET AND DEATH <u>3 Days</u> <u>2 YRS</u> <u>DIABETES 3 YRS.</u> <u>6 weeks</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>May 1960</u> to <u>August 1960</u> and last saw him alive on <u>8-25-1960</u> Death occurred at <u>2:30 P.</u> m on the date stated above, and to the best of my knowledge, from the causes stated.					
22a. SIGNATURE (Degree or title) <u>M. E. Humphrey D.D. DO</u>			22b. ADDRESS <u>Tuscumbia - Mo</u>		22c. DATE SIGNED <u>27 Aug-60</u>
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL -</u>	23b. DATE <u>27 Aug-1960</u>	23c. NAME OF CEMETERY OR CREMATORY <u>New-Hope</u>	23d. LOCATION (City, town, or county) <u>KAISER -</u>		(State) <u>MO</u>
24. FUNERAL DIRECTOR ADDRESS <u>Keith McKays</u>		25. DATE RECD. BY LOCAL REG. <u>ELDON MO 8-27-60</u>	26. REGISTRAR'S SIGNATURE <u>Mrs. W. E. Kallenboch</u>		

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

0961
OCT 3 8 100

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 Keith M. Days

Licensed Embalmer No. 3928

P. O. Address Edon Mo

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.