

JRI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-60-031415

AUG 19 1960

Registration District No. 231 Primary Registration District No. 5813 Registrar's No. 39

STATE FILE NUMBER

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Montgomery</u>				
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Wellsville, Mo. Upper Loutree</u>		Length of stay in 1b		c. CITY OR TOWN <u>Wellsville Mo</u>		Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>		
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>RR #1</u>			Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>		d. STREET ADDRESS (If outside, give location) <u>RR#1</u>		Reside on Farm Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>MARY</u> Middle <u>MAY</u> Last <u>WHITEHEAD</u>				4. DATE OF DEATH Month <u>July</u> Day <u>27</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>JAN. 3, 1889</u>	9. AGE (last birthday) <u>71</u>	IF UNDER 1 YEAR Months <u>6</u> Days <u>24</u>	IF UNDER 24 HR Hours <u></u> Min. <u></u>	
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>at Home</u>		11. BIRTHPLACE (City and state or country) <u>Wellsville, Mo</u>		12. CITIZEN OF WHAT COUNTRY <u>U. S. A</u>	
13a. FATHER'S NAME <u>Jack Stone</u>			13b. MOTHER'S MAIDEN NAME <u>Laura Dillon</u>		14. NAME OF HUSBAND OR WIFE <u>Ollie Whitehead</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>498-05-6331</u>		17. INFORMANT <u>Paul Whitehead, Wellsville, Mo</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>Coronary thrombosis</u>							INTERVAL BETWEEN ONSET AND DEATH <u>30 m</u>	
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) DUE TO (c)								
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 checked="" 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 <u></u> a.m. <u></u> p.m. <u></u>		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>July 27, 1960</u> to <u>July 27, 1960</u> last saw her <u>alive on July 27, 1960</u> Death occurred at <u>July 27, 1960 3 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>Willis H. Walker MD</u>				22b. ADDRESS <u>Wellsville Mo</u>		22c. DATE SIGNED <u>8/29/60</u>		
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE <u>July 29, 1960</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Wellsville Cemetery</u>		23d. LOCATION (City, town, or county) <u>Wellsville, Mo</u> (State)			
24. FUNERAL DIRECTOR <u>Wells Funeral Home, Wellsville, Mo</u>				25. DATE RECD. BY LOCAL REG. <u>7/28/60</u>		26. REGISTRAR'S SIGNATURE <u>Laura S. Callaway</u>		

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

JAN 27 1961

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. 1

working under my personal supervision.

Student _____

Signature of Student Embalmer

Signed Howard F. Myers

Licensed Embalmer No. 1494

P. O. Address Wellsville,

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