

RI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

=60-031664

LED VS SEP 12 1960

Registration District No. 294 Primary Registration District No. 3056 Registrar's No. 220

STATE FILE NUMBER

1. PLACE OF DEATH a. COUNTY <u>RANDOLPH</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MO</u> b. COUNTY <u>MONROE</u>			
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>MOBERLY</u>		Length of stay in 1b <u>7 DAYS</u>		c. CITY OR TOWN <u>JACKSON TWP.</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>COMMUNITY HDSP.</u>			Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <u>3 M.S. W. OF PARIS MO.</u>		Reside on Farm Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>SARAH</u> Middle <u>ELIZABETH</u> Last <u>HANN</u>				4. DATE OF DEATH Month <u>AUG.</u> Day <u>29</u> Year <u>1960</u>			
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>		8. DATE OF BIRTH <u>3/19/1875</u>	9. AGE (last birthday) <u>85</u>	IF UNDER 1 YEAR Months <u>3</u> Days <u>20</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>AT HOME</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>AT HOME</u>		11. BIRTHPLACE (City and state or country) <u>MONROE CO, MO.</u>		12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>	
13a. FATHER'S NAME <u>ELI RONEY</u>			13b. MOTHER'S MAIDEN NAME <u>MAHALA J. FOREE</u>		14. NAME OF HUSBAND OR WIFE <u>HOWARD N.</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>NONE</u>	17. INFORMANT Address <u>R.F. DIEZ</u> <u>CHARLES F. HANN PARIS, 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>Hypostatic Pneumonia</u> DUE TO (b) <u>Chronic Myocarditis</u> DUE TO (c) <u>Senility</u> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.						INTERVAL BETWEEN ONSET AND DEATH <u>6 hrs.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>Fracture of Left Femur</u>					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 _____ a.m. _____ p.m. Month, Day, Year _____							
20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" 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>8-22-60</u> to <u>8-28-60</u> and last saw her <u>alive</u> on <u>8-28-60</u> Death occurred at <u>3:40 P.M.</u> on the date stated above, and to the best of my knowledge, from the causes stated.							
22a. SIGNATURE (Degree or title) <u>W. H. McConick D.O.</u>				22b. ADDRESS <u>Moberly, MO.</u>		22c. DATE SIGNED <u>8-30-60</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	23b. DATE <u>AUG. 29, 1960</u>	23c. NAME OF CEMETERY OR CREMATORY <u>WALNUT GROVE</u>		23d. LOCATION (City, town, or county) (State) <u>PARIS, MO.</u>			
24. FUNERAL DIRECTOR ADDRESS <u>E. HAGNEW PARIS, MO.</u>			25. DATE RECD. BY LOCAL REG. <u>8-28-60</u>		26. REGISTRAR'S SIGNATURE <u>Teaburline</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 E.H. Agnew

Licensed Embalmer No. 4000

P. O. Address Paris, W.

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.