URI DIVISION OF HEALTH – STANDARD CERTIFICATE OF DEATH

ILED VS AUG 24 1960

60-031780

STATE FILE NUMBER

Registration District No. 316 Primary Registration District No. — Registrar's No. 317

NDED

1. PLACE OF DEATH
a. COUNTY St. Francois
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN St. Francois Township — Length of stay in Ib 26das.
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION State Hospital No. 4 — Inside Limits Yes ☐ No ☒

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Missouri b. COUNTY Butler
c. CITY OR TOWN Fisk — Inside Limits Yes ☐ No ☒
d. STREET ADDRESS (If outside, give location) Route 1 — Reside on Farm Yes ☐ No ☐ Unknown

3. NAME OF DECEASED (Type or print) First CARMON Middle — Last DeFORD
4. DATE OF DEATH Month August Day 13 Year 1960
5. SEX Male
6. COLOR OR RACE White
7. Married ☐ Never Married ☒ Widowed ☐ Divorced ☐
8. DATE OF BIRTH Aug. 24, 1919
9. AGE (last birthday) 40 — IF UNDER 1 YEAR Months 11 Days 20 — IF UNDER 24 HR Hours — Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None
10b. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (City and state or country) Savannah, Tennessee
12. CITIZEN OF WHAT COUNTRY U.S.A.
13a. FATHER'S NAME Charles DeFord
13b. MOTHER'S MAIDEN NAME Camilla Horton
14. NAME OF HUSBAND OR WIFE
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. None
17. INFORMANT Address Records State Hospital No.4, Farmington, Mo.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Coronary Occlusion - - - - - - - - - - - - instantaneous.
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.
DUE TO (b)
DUE TO (c)
INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)
Psychosis with Mental deficiency and epilepsy.
PART III. If deceased was female was there a pregnancy in last 90 days. ☐ Yes ☐ No ☐ Unknown
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒
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 18, 1960, to August 13, 1960 and last saw him alive on August 13, 1960
Death occurred at 11:35 A. M. on the date stated above, and to the best of my knowledge, from the causes stated.

BY AFFIDAVIT OF

22a. SIGNATURE (Degree or title) [signature] D.O.
22b. ADDRESS State Hospital No. 4 Farmington, Missouri
22c. DATE SIGNED 8-13-60

23a. BURIAL, CREMATION, REMOVAL (Specify) Burial
23b. DATE 8-15-60
23c. NAME OF CEMETERY OR CREMATORY Shain Memorial Cemetery
23d. LOCATION (City, town, or county) (State) Fisk, Missouri

24. FUNERAL DIRECTOR ADDRESS White Funeral Home, Fisk, Mo.
25. DATE RECD. BY LOCAL REG. Aug. 13, 1960
26. REGISTRAR'S SIGNATURE Esther Rudloff

(Licensed Embalmer's Statement on Reverse Side)

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 _____

Signature of Student Embalmer

Licensed Embalmer No. 4120

P. O. Address _____

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