

**MURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH**

**-60-033704**

**FILED VS OCT 11 1960**

UNRECORDED

Registration District No. 4 Primary Registration District No. \_\_\_\_\_ Registrar's No. 228

STATE FILE NUMBER

1. PLACE OF DEATH a. COUNTY <b>Atchison</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Missouri</b> COUNTY <b>Atchison</b>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>Fairfax</b>	Length of stay in 1b <b>2 Months</b>	c. CITY OR TOWN <b>Tarkio</b>	Inside Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (if NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>Community Hospital</b>	Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location)	Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>

3. NAME OF DECEASED (Type or print) <b>Alta Elizabeth Hills</b>	4. DATE OF DEATH <b>Oct-1st -1960</b>
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5. SEX <b>Female</b>	6. COLOR OR RACE <b>Wh</b>	7. Married <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <b>May-4-1894</b>	9. AGE (last birthday) <b>66</b>	IF UNDER 1 YEAR Months _____ Days _____	IF UNDER 24 HR Hours _____ Min. _____
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10a. USUAL OCCUPATION (Give kind of work done during working life, even if retired) <b>urse</b>	10b. KIND OF BUSINESS OR INDUSTRY <b>General Nursing</b>	11. BIRTHPLACE (City and state or country) <b>Iowa</b>	12. CITIZEN OF WHAT COUNTRY <b>U S</b>
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13a. FATHER'S NAME <b>Joseph Hills</b>	13b. MOTHER'S MAIDEN NAME <b>Luella Boyer</b>	14. NAME OF HUSBAND OR WIFE
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>	16. SOCIAL SECURITY NO. <b>487-42-6819</b>	17. INFORMANT <b>Loyd Hills</b>	Address <b>Tarkio, Missouri</b>
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18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY:		INTERVAL BETWEEN ONSET AND DEATH <b>days</b> <b>years</b>
IMMEDIATE CAUSE (a) <b>Cerebral hemorrhage</b>		
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) <b>Cerebral arteriosclerosis</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
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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.)
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20c. TIME OF INJURY Hour _____ a.m. _____ p.m.	Month, Day, Year
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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 _____
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21. I attended the deceased from **Aug, 1960** to **10/1/60** and last saw her/him alive on **10/1/60**  
Death occurred at **7:00 P.m.** on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) <b>John M. Wansmaker M.D.</b>	22b. ADDRESS <b>Rock Port, Mo.</b>	22c. DATE SIGNED <b>10/3/60</b>
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23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Removal</b>	23b. DATE <b>Oct-3-1960</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Blanchard Cemetery</b>	23d. LOCATION (City, town, or county) (State) <b>Blanchard, Iowa</b>
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24. FUNERAL DIRECTOR <b>Tucker Funeral Home</b>	ADDRESS <b>Westboro, Mo</b>	25. DATE RECD. BY LOCAL REG. <b>Oct 6, 1960</b>	26. REGISTRAR'S SIGNATURE <b>Marvin H. Schuler</b>
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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 me  
or by \_\_\_\_\_, Student Embalmer No. \_\_\_\_\_  
working under my personal supervision.

Student \_\_\_\_\_  
Signature of Student Embalmer

Signed *Ashley R. Stone*

Licensed Embalmer No. 4757

P. O. Address Westboro, Mi

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.