

RI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

FILED VS OCT 10 1960

-60-033831
STATE FILE NUMBER

Registration District No. 38 Primary Registration District No. 3006 Registrar's No. 562

| | | | | | | |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|
| 1. PLACE OF DEATH a. COUNTY <u>BOONE</u> | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MO.</u> b. COUNTY <u>BOONE</u> | | | |
| b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Columbia</u> | | Length of stay in 1b <u>3 days</u> | c. CITY OR TOWN <u>HALLSVILLE</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>UNIVERSITY of MISSOURI Medical Center</u> | | Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/> | d. STREET ADDRESS <u>RT-1</u> (If outside, give location) | | Reside on Farm Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) First <u>Albert</u> Middle <u>—</u> Last <u>Wise</u> | | | 4. DATE OF DEATH Month <u>Oct</u> Day <u>5</u> Year <u>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>3-10-99</u> | 9. AGE (last birthday) <u>61</u> IF UNDER 1 YEAR IF UNDER 24 HR Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>FARMER</u> | | 10b. KIND OF BUSINESS OR INDUSTRY <u>FARMER</u> | | 11. BIRTHPLACE (City and state or country) <u>Columbia Mo.</u> | 12. CITIZEN OF WHAT COUNTRY <u>U. S.</u> | |
| 13a. FATHER'S NAME <u>John Wise</u> | | 13b. MOTHER'S MAIDEN NAME <u>PETRO ELIZABETH</u> | | 14. NAME OF HUSBAND OR WIFE <u>Edna Enloe</u> | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>NONE</u> (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. <u>NONE Unknown</u> | 17. INFORMANT <u>Medicals Records</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>Hepatic FAILURE</u> DUE TO (b) <u>Cirrhosis of The Liver</u> DUE TO (c) _____ Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. | | | | | INTERVAL BETWEEN ONSET AND DEATH <u>7 days</u> <u>3 more</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 checked="" type="checkbox"/> NO <input 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>OCT. 1, 1960</u> to <u>OCT. 5, 1960</u> and last saw ^{her} him alive on <u>OCT 5, 1960</u> Death occurred at <u>8:45</u> <u>p</u> m on the date stated above, and to the best of my knowledge, from the causes stated. | | | | | | |
| 22a. SIGNATURE <u>J. H. Tuttle</u> (Degree or title) <u>M.D.</u> | | | 22b. ADDRESS <u>University Hospital, Columbia</u> | | 22c. DATE SIGNED <u>10-6-60</u> | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u> | 23b. DATE <u>10-7-1960</u> | 23c. NAME OF CEMETERY OR CREMATORY <u>Oakland Cemetery</u> | 23d. LOCATION (City, town, or county) <u>Boone Co., Missouri</u> | 23e. (State) | | |
| 24. FUNERAL DIRECTOR <u>Parson Funeral Service, Columbia, Mo.</u> | | ADDRESS | 25. DATE RECD. BY LOCAL REG. <u>Oct. 7, 1960</u> | 26. REGISTRAR'S SIGNATURE <u>Mrs. R.E. Palmer</u> | | |

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

0961 T T 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 _____, Student Embalmer No. _____
or by _____, Student Embalmer No. _____
working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed J.W. Phillips
Licensed Embalmer No. 4897

P. O. Address Columbus, Ga.

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