

# FRI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

FILED VS SEP 22 1960

-60-034204

Registration District No. 75 Primary Registration District No. 3015 Registrar's No. 102

STATE FILE NUMBER

INDEXED

1. PLACE OF DEATH a. COUNTY <b>Clinton</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Mo</b> b. COUNTY <b>DeKalb</b>				
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>Cameron</b>			Length of stay in 1b <b>30 Min.</b>		c. CITY OR TOWN <b>Osborn</b>		Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
c. FULL NAME OF (IF NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>Cameron Community Hosp</b>				Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location) <b></b>		Reside on Farm Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <b>DONALD</b> Middle <b>Eugene</b> Last <b>KARR</b>			4. DATE OF DEATH Month <b>9</b> Day <b>10</b> Year <b>1960</b>					
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</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>4-10-1947</b>	9. AGE (last birthday) <b>13</b>	IF UNDER 1 YEAR Months <b></b> Days <b></b>	IF UNDER 24 HR Hours <b></b> Min. <b></b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>In school</b>			10b. KIND OF BUSINESS OR INDUSTRY <b></b>		11. BIRTHPLACE (City and state or country) <b>Osborn Mo (Rural)</b>		12. CITIZEN OF WHAT COUNTRY <b>U.S.</b>	
13a. FATHER'S NAME <b>Frank Karr</b>			13b. MOTHER'S MAIDEN NAME <b>Adeline Case</b>			14. NAME OF HUSBAND OR WIFE <b></b>		
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></b>		17. INFORMANT <b>Frank Karr Osborn Mo.</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Massive Hemorrhage</i> DUE TO (b) <i>Multiple Traumatic Amputations</i> DUE TO (c) <i></i> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.							INTERVAL BETWEEN ONSET AND DEATH <i>1 1/2 hrs</i> <i>1 1/2 hrs</i>	
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 type="checkbox"/> NO <input checked="" type="checkbox"/>	20a. ACCIDENT <input checked="" 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.) <i>Fell from tractor into brush cutter.</i>				
20c. TIME OF INJURY <i>7:00 p.m.</i>	Hour <b></b> Month, Day, Year <b>9-10-60</b>							
20d. INJURY OCCURRED WHILE AT WORK <input checked="" 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.) <i>Farm</i>		20f. CITY, TOWN, OR LOCATION <i>Osborn</i>		COUNTY <i>DeKalb</i>	STATE <i>Mo.</i>	
21. I attended the deceased from <i>8:40 p.m.</i> on the date stated above, and to the best of my knowledge, from the causes stated. Death occurred at <i>9-10-60</i> and last saw him alive on <i>9-10-60</i>								
22a. SIGNATURE <i>D. O. Bloom</i> (Degree or title)				22b. ADDRESS <i>Cameron Mo</i>			22c. DATE SIGNED <i>9-12-60</i>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Removal</b>		23b. DATE <b>9 13 1960</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Evergreen</b>		23d. LOCATION (City, town, or county) <b>Osborn Mo.</b>			
24. FUNERAL DIRECTOR <b>Pilcher Funeral Home Maysville Mo</b>				ADDRESS <b></b>		25. DATE RECD. BY LOCAL REG. <b>9-12-60</b>	26. REGISTRAR'S SIGNATURE <i>Francis W. Crawford</i>	

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 \_\_\_\_\_



C.T. Plucher

Licensed Embalmer No. 3960

P. O. Address Maysville Mo.

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.