

JRI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-60-034276

FILED VS SEP 27 1960

Registration District No. 096 Primary Registration District No. _____ Registrar's No. 65 STATE FILE NUMBER

ENDED

1. PLACE OF DEATH a. COUNTY <u>Dallas</u>			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Dallas</u>				
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>S. Benton Twp.</u>		Length of stay in 1b <u>1 Yr.</u>		c. CITY OR TOWN <u>Buffalo,</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>5 Mi. S. E. of Buffalo</u>			Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>		d. STREET ADDRESS (If outside, give location) <u>5 Mi. S. E. of Buffalo</u>		Reside on Farm Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Middle Last <u>JOHN WESLEY ATKINSON</u>			4. DATE OF DEATH Month Day Year <u>Sept. 11 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>July 16, 1892</u>	9. AGE (last birthday) <u>68</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>farming</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>retired</u>		11. BIRTHPLACE (City and state or country) <u>Licking, Mo.</u>		12. CITIZEN OF WHAT COUNTRY <u>U. S. A.</u>	
13a. FATHER'S NAME <u>Jackson Atkinson</u>		13b. MOTHER'S MAIDEN NAME <u>Palestine Owens</u>		14. NAME OF HUSBAND OR WIFE <u>Dalsin Mae Atkinson</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.		17. INFORMANT Address <u>Jim Atkinson Buffalo, 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>Coronary thrombosis</u>						INTERVAL BETWEEN ONSET AND DEATH <u>24 hrs</u>	
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <u>Arteriosclerotic = severe</u>							
DUE TO (c) <u>Hypertension</u>						<u>12 yrs.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART (a) <u>Chr. Silicosis + Bronchitis</u>					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 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>1948</u> , to <u>9-11-60</u> and last saw ^{her} him alive on <u>9-11-60</u> Death occurred at <u>5130 a.</u> m on the date stated above, and to the best of my knowledge, from the causes stated.							
22a. SIGNATURE (Degree or title) <u>C.O. Jamison M.D.</u>			22b. ADDRESS <u>Buffalo, Mo.</u>		22c. DATE SIGNED <u>9-12-60</u>		
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>burial</u>		23b. DATE <u>Sept. 13, 1960</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Oak Lawn</u>		23d. LOCATION (City, town, or county) <u>Buffalo, Mo.</u> (State)	
24. FUNERAL DIRECTOR ADDRESS <u>L. B. Jones Buffalo, Mo.</u>			25. DATE RECD. BY LOCAL REG. <u>9/26/60</u>		26. REGISTRAR'S SIGNATURE <u>Mrs Vera Petree</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 R. E. Cheatham

Licensed Embalmer No. 3813
P. O. Address Buffalo, N. Y.

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.