

RI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-60-034577

FILED VS OCT 10 1960

Registration District No. 141 Primary Registration District No. 3025 Registrar's No. 139

STATE FILE NUMBER

|  |  |   |   |  |  |  |  |
|--|--|---|---|--|--|--|--|
| 1. PLACE OF DEATH<br>a. COUNTY <i>Howes</i>  |  |   |   | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <i>Mo</i> b. COUNTY <i>Howes</i> |  |  |  |
| b. CITY (If outside corporate limits, give TOWNSHIP only)<br><i>West Plains</i>  |  | Length of stay in 1b<br><i>454</i>  |   | c. CITY OR TOWN<br><i>West Plains</i>  |  | Inside Limits<br>Yes <input type="checkbox"/> No <input type="checkbox"/>  |  |
| c. FULL NAME OF HOSPITAL OR INSTITUTION<br><i>Springfield St.</i>  |  |   | Inside Limits<br>Yes <input type="checkbox"/> No <input type="checkbox"/> |  | d. STREET ADDRESS (If outside, give location)<br><i>Missouri Ave</i> |  | Reside on Farm<br>Yes <input type="checkbox"/> No <input type="checkbox"/> |
| 3. NAME OF DECEASED (Type or print)<br><i>Betty Dean</i>   |  |   |   | 4. DATE OF DEATH<br>Month <i>9</i> Day <i>11</i> Year <i>60</i>  |  |  |  |
| 5. SEX<br><i>F</i>   | 6. COLOR OR RACE<br><i>W</i>           | 7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/><br>Widowed <input type="checkbox"/> Divorced <input type="checkbox"/> |   | 8. DATE OF BIRTH<br><i>4-18-63</i>   | 9. AGE (last birthday)<br><i>97</i>                                  | IF UNDER 1 YEAR<br>Months <i>7</i> Days <i>7</i>   | IF UNDER 24 HR<br>Hours <i>7</i> Min. <i>0</i>                             |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><i>Wife</i>   |  |   | 10b. KIND OF BUSINESS OR INDUSTRY<br><input checked="" type="checkbox"/>  |  | 11. BIRTHPLACE (City and state or country)<br><i>Mobile Co, Mo</i>   |  | 12. CITIZEN OF WHAT COUNTRY<br><i>USA</i>                                  |
| 13a. FATHER'S NAME<br><i>?</i>   |  |   | 13b. MOTHER'S MAIDEN NAME<br><i>?</i>                                     |  |  | 14. NAME OF HUSBAND OR WIFE<br><i>?</i>  |  |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)<br><input checked="" type="checkbox"/>   |  |   | 16. SOCIAL SECURITY NO.<br><input checked="" type="checkbox"/>            |  | 17. INFORMANT<br><i>Egora James West Plains Mo</i>                   |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <i>Congestive heart failure</i>  |  |   |   |  |  | INTERVAL BETWEEN ONSET AND DEATH<br><i>6 mo</i>  |  |
| Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.<br>DUE TO (b) <i>arteriosclerotic heart disease</i>   |  |   |   |  |  | <i>3 year</i>  |  |
| 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.<br><input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown |  |
| 19. WAS AUTOPSY PERFORMED? YES <input 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<br>Hour <i>10:00 A.</i><br>a.m. <i>10:00</i> p.m. <i>00</i>  |  | Month, Day, Year<br><i>9/11/60</i>  |   |  |  |  |  |
| 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<br><i>West Plains Mo</i>  |  | COUNTY STATE   |  |
| 21. I attended the deceased from <i>1957</i> to <i>9/11/60</i> and last saw her alive on <i>9/1/60</i><br>Death occurred at <i>10:00 A.</i> on the date stated above, and to the best of my knowledge, from the causes stated. |  |   |   |  |  |  |  |
| 22a. SIGNATURE (Degree or title)<br><i>M. L. Fowler MD</i>   |  |   |   | 22b. ADDRESS<br><i>West Plains Mo</i>  |  | 22c. DATE SIGNED<br><i>9/29/60</i>   |  |
| 23a. BURIAL, CREMATION, REMAINS (Specify)<br><i>10-5-60</i>  |  | 23b. DATE<br><i>10-5-60</i>   |   | 23c. NAME OF CEMETERY OR CREMATORY<br><i>Bellevue Sprigs</i>   |  | 23d. LOCATION (City, town, or county) (State)<br><i>Dart, Mo</i>   |  |
| 24. FUNERAL DIRECTOR<br><i>Tabertson West Plains Mo</i>  |  |   | 25. DATE RECD. BY LOCAL REG.<br><i>10-5-60</i>                            |  | 26. REGISTRAR'S SIGNATURE<br><i>Beatrice Cook</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  
or by \_\_\_\_\_, Student Embalmer No. \_\_\_\_\_  
working under my personal supervision.

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

Signed *A. S. Roberts*

Licensed Embalmer No. 348

P. O. Address West 7

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.