

JR DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-60-034583

INDEXED

Registration District No. 141 Primary Registration District No. 3025 Registrar's No. 140 STATE FILE NUMBER

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|--|--|--|---|
| 1. PLACE OF DEATH a. COUNTY <u>Adams</u> | | 2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE <u>Mo.</u> b. COUNTY <u>Douglas</u> | |
| b. CITY (If outside corporate limits, give TOWNSHIP only) <u>West Plains</u> | | Length of stay in lb <u>mo's</u> | c. CITY OR TOWN <u>Petersville</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>Keena Rest Home</u> | | Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> | d. STREET ADDRESS (If outside, give location) <u>RFD</u> Reside on Farm Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> |

3. NAME OF DECEASED (Type or print) First Middle Last Margie M. Sutton 4. DATE OF DEATH 9-20-60 Month Day Year

5. SEX F 6. COLOR OF RACE W 7. Married Never Married Widowed Divorced 8. DATE OF BIRTH 10-17-76 9. AGE (last birthday) 83 IF UNDER 1 YEAR Months Days IF UNDER 24 HR Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Nurse 10b. KIND OF BUSINESS OR INDUSTRY Nursing 11. BIRTHPLACE (City and state or country) Pennsylvania 12. CITIZEN OF WHAT COUNTRY USA

13a. FATHER'S NAME Joe E. Shump 13b. MOTHER'S MAIDEN NAME Mary E. Blank 14. NAME OF HUSBAND OR WIFE Walter Sutton

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No 16. SOCIAL SECURITY NO. 1-4-60-100000000 17. INFORMANT Ada Wetherington Address West Plains Mo

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Uremia INTERVAL BETWEEN ONSET AND DEATH 6 weeks
DUE TO (b) Chronic pyelonephritis 6 months
DUE TO (c) _____
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) Fractured hip PART III. If deceased was female was there a pregnancy in last 90 days. Yes No Unknown

19. WAS AUTOPSY PERFORMED? YES NO 20a. ACCIDENT SUICIDE HOMICIDE 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)

20c. TIME OF INJURY Hour Month, Day, Year
a.m. p.m.

20d. INJURY OCCURRED WHILE AT WORK NOT WHILE AT WORK 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 April 1960 to 9/20/60 and last saw her 9/19/60 alive on 9/19/60
Death occurred at 12:30 A. m on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) M. L. Fowler MD 22b. ADDRESS West Plains Mo 22c. DATE SIGNED 9/29/60

23a. BURIAL, CREMATION, REINTERMENT (Specify) B 23b. DATE 9/22-60 23c. NAME OF CEMETERY OR CREMATORY Oak Haven 23d. LOCATION (City, town, or county) (State) Petersville Mo

24. FUNERAL DIRECTOR Robertson, West Plains Mo ADDRESS 10-5-60 25. DATE RECD. BY LOCAL REG. 10-5-60 26. REGISTRAR'S SIGNATURE Beatrice Cook

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. K...

Licensed Embalmer No. *3437*

P. O. Address *West 7th*

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.