

RI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-60-034796

FILED VS OCT 1 0 1960

Registration District No. 149 Primary Registration District No. 1002 Registrar's No. 4815 STATE FILE NUMBER

1. PLACE OF DEATH a. COUNTY <u>Jackson</u>		2. USUAL RESIDENCE (Where deceased lived) If institution: Residence before admission) a. STATE <u>Mo.</u> b. COUNTY <u>Jackson</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) <u>Wassonville</u> OR TOWNSHIP		Length of stay in 1b <u>13 yrs.</u>	c. CITY OR TOWN <u>Wassonville</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>General Hosp.</u>		Inside limits Yes <input type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <u>1617 Olive</u> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print) First <u>Savannah</u> Middle <u>Henry</u> Last <u>Henry</u>			4. DATE OF DEATH Month <u>9</u> Day <u>19</u> Year <u>60</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>Caucasian</u>	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <u>3/31/1911</u>	9. AGE (last birthday) <u>79</u>	IF UNDER 1 YEAR Months <u>0</u> Days <u>0</u> Hours <u>0</u> Min. <u>0</u>	
10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (City and state or country) <u>Washington Penn. USA</u>		
12a. FATHER'S NAME <u>Walter Grayson</u>		12b. MOTHER'S MAIDEN NAME <u>Lula Smith</u>		14. NAME OF HUSBAND OR WIFE <u>John Henry</u>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT <u>Oliver B. North - 1617 Olive</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>Perforated duodenal ulcer with peritonitis</u>		INTERVAL BETWEEN ONSET AND DEATH
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) _____ 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. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	
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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.)
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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 checked="" type="checkbox"/>	20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	20f. CITY, TOWN, OR LOCATION <u>Wassonville</u>	COUNTY _____ STATE _____
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21. I attended the deceased from <u>9/7/1960</u> to <u>9/19/60</u> and last saw her <u>alive</u> on <u>9-19-60</u> Death occurred at _____ on the date stated above, and to the best of my knowledge, from the causes stated.
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22a. SIGNATURE (Degree or title) <u>H. L. Dwyer</u>	22b. ADDRESS <u>Mo. Shoehorn, Mo.</u>	22c. DATE SIGNED <u>9/19/60</u>
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23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE <u>9-22-60</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Lincoln</u>	23d. LOCATION (City, town, or county) (State) <u>W.C. Jones</u>
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24. FUNERAL DIRECTOR <u>Watkins Bros. - 18th & Benton</u>	25. DATE RECD. BY LOCAL REG. <u>9.22.60</u>	26. REGISTRAR'S SIGNATURE <u>H. L. Dwyer</u>
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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 _____
Bruce R. W...

Licensed Embalmer No. 450

P. O. Address 1 Pch & Be...

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.