

FEDERAL DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-60-035393

FILED VS. SEP 20 1960

Registration District No. 383 Primary Registration District No. 5655 Registrar's No. 82

STATE FILE NUMBER

1. PLACE OF DEATH a. COUNTY Lawrence				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY Jackson					
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Mt. Vernon		Length of stay in 1b 75 days		c. CITY OR TOWN Kansas City		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>			
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Missouri State Sanatorium			Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS 1216 Woodland (If outside, give location)		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First Joe Middle Settles Last Settles				4. DATE OF DEATH Month September Day 13 Year 1960					
5. SEX male	6. COLOR OR RACE colored	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>		8. DATE OF BIRTH 2-11-97	9. AGE (last birthday) 63	IF UNDER 1 YEAR Months <input type="checkbox"/> Days <input type="checkbox"/>	IF UNDER 24 HR Hours <input type="checkbox"/> Min. <input type="checkbox"/>		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Painter			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (City and state or country) Fayette, Missouri		12. CITIZEN OF WHAT COUNTRY United States		
13a. FATHER'S NAME John Settles			13b. MOTHER'S MAIDEN NAME Rosetta Ashcraft			14. NAME OF HUSBAND OR WIFE Alberta Settles			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or No known) (If yes, give war or dates of service) No			16. SOCIAL SECURITY NO. 500-168265		17. INFORMANT Patient		Address Kansas City, Missouri		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Congestive heart failure							INTERVAL BETWEEN ONSET AND DEATH		
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) Cor Pulmonale									
DUE TO (c) Far-advanced, active, pulmonary tuberculosis									
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 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 <input type="checkbox"/> 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 June 30, 1960 to September 13, 1960 and last saw her September 13, 1960		Death occurred at 4:50 p on the date stated above, and to the best of my knowledge, from the causes stated.							
22a. SIGNATURE <i>Samuel R. Wilson M.D.</i> (Degree or title)				22b. ADDRESS Missouri State Sanatorium Mt. Vernon, Mo.				22c. DATE SIGNED 9-13-60	
23a. BURIAL, CREMATION, REMOVAL (Specify) Buried	23b. DATE 9/16/60	23c. NAME OF CEMETERY OR CREMATORY Columbia Cem.			23d. LOCATION (City, town, or county) (State) Columbia Mo				
24. FUNERAL DIRECTOR Myrtal Parker				ADDRESS Columbia, Mo.		25. DATE RECD. BY LOCAL REG. 9-13-60		26. REGISTRAR'S SIGNATURE <i>H.H. Fossitt</i>	

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

SEP 29 1960

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 George P. Grammel

Licensed Embalmer No. 4425

P. O. Address Columbia

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to conform 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.