

Health,
Welfare
Public
Service

FILED VS SEP 21 1960

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

-60-035432

Registration District No. 385 Primary Registration District No. 3039 STATE FILE NUMBER
Registrar's No. 149

1. PLACE OF DEATH a. COUNTY <u>Linn</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Mo</u> b. COUNTY <u>Linn</u>	
b. CITY OR TOWN <u>Marceline</u> (If outside corporate limits, give TOWNSHIP only)		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <u>Marceline</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>St. Francis Hosp</u>		Length of stay in lb. <u>6da.</u>	d. STREET ADDRESS (If outside, give location) <u>05812 303 W. Santa Fe</u> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print) First <u>Mary</u> Middle <u>E.</u> Last <u>Herbert</u>			4. DATE OF DEATH Month <u>9</u> Day <u>16</u> Year <u>1960</u>		
5. SEX <u>1 F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>3-8-1872</u>		9. AGE (In years last birthday) <u>88</u> IF UNDER 1 YEAR: Months <u>4</u> Days <u>8</u> IF UNDER 24 HRS: Hours <u></u> Min. <u></u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Nurse/keeper</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Same</u>	11. BIRTHPLACE (City and state or country) <u>Breckenridge, MO</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>

13a. FATHER'S NAME <u>William</u>		13b. MOTHER'S MAIDEN NAME <u>Harriett Maddox</u>		14. NAME OF HUSBAND OR WIFE <u>None</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. <u>None</u>	17. INFORMANT <u>C.W. Herbert</u> Address <u>Marceline, 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>Pneumonia</u>			INTERVAL BETWEEN ONSET AND DEATH <u>3 days</u>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <u>arteriosclerosis & cerebral degeneration</u> DUE TO (c) <u>4500</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>Hypertension on Pt. - Chronic Urinary Infection -</u>			19. WAS AUTOPSY PERFORMED? 2 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 <u></u> Month, Day, Year a.m. <u></u> p.m. <u></u>					

20d. INJURY OCCURRED WHILE AT <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>Aug 1960</u> to <u>Sept 1960</u> and last saw her alive on <u>9-16-60</u> Death occurred at <u></u> m on the date stated above; and to the best of my knowledge, from the causes stated.					

22. SIGNATURE <u>James M. Laughlin</u> (Degree or title)		22b. ADDRESS <u>Marceline, Missouri</u>		22c. DATE SIGNED <u>9-16-60</u>	
---	--	--	--	------------------------------------	--

23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE <u>9-18-60</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Mt. Olivet</u>		23d. LOCATION (City, town, or county) (State) <u>Marceline, Mo</u>	
---	--	-----------------------------	--	---	--	---	--

24. FUNERAL DIRECTOR <u>James M. Laughlin</u> ADDRESS <u>Marceline MO</u>		25. DATE RECD. BY LOCAL REG. <u>9-18-60</u>		26. REGISTRAR'S SIGNATURE <u>Brooke Owens</u>	
--	--	--	--	--	--

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

All diseases in Part I must be causally related.

300
1-57

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or by, Student Embalmer No. working under my personal supervision.

Student
Signature of Student Embalmer

Signed *Geard I. Wade*

Licensed Embalmer No. *4172*

P. O. Address *Bronx*

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.