

STATE DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

FILED VS SEP 19 1960

-60-035444

STATE FILE NUMBER

Registration District No. 187 Primary Registration District No. 3040 Registrar's No. 167

1. PLACE OF DEATH a. COUNTY Livingston				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY Carroll				
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Chillicothe		Length of stay in 1b 10 days		c. CITY OR TOWN Hale		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION City Hospital			Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location) None		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Russell Middle Janinson Last Janinson				4. DATE OF DEATH Month Sept. Day 8 Year 1960				
5. SEX Male	6. COLOR OR RACE White	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>		8. DATE OF BIRTH July 27 1877		9. AGE (last birthday) 83	IF UNDER 1 YEAR Months 1 Days 22	IF UNDER 24 HR Hours 22 Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Mail carrier			10b. KIND OF BUSINESS OR INDUSTRY U.S. Mail		11. BIRTHPLACE (City and state or country) Hale, Missouri		12. CITIZEN OF WHAT COUNTRY U.S.A.	
13a. FATHER'S NAME James Janinson			13b. MOTHER'S MAIDEN NAME Susana Hudson			14. NAME OF HUSBAND OR WIFE May Janinson Dec.		
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.		17. INFORMANT Mrs. Eulavee VanDergrift			Address
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pneumonia, Terminal, Bronchial DUE TO (b) Ulcer of stomach, with hemorrhage DUE TO (c) _____ Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.								INTERVAL BETWEEN CAUSE AND DEATH 1 day 6 days
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 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 _____ a.m. _____ p.m.		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 Sept. 2-60 to Sept. 8-60 and last saw him alive on Sept. 7-60 Death occurred at 5 A M on the date stated above, and to the best of my knowledge, from the causes stated.								
22a. SIGNATURE Joseph A. Conrad M.D. (Degree or title)				22b. ADDRESS Chillicothe, Mo		22c. DATE SIGNED Sept 14 60 (State)		
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE Sept. 10, 60	23c. NAME OF CEMETERY OR CREMATORY Hale em		23d. LOCATION (City, town, or county) Hale Missouri				
24. FUNERAL DIRECTOR Clifford W; Austin ADDRESS Hale Mo.			25. DATE RECD. BY LOCAL REG. Sept. 14, 1960		26. REGISTRAR'S SIGNATURE Annalee Taylor			

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



Licensed Embalmer No. 482

P. O. Address Chillicothe

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.