

RI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

FILED VS. SEP 29 1960

-60-035545
STATE FILE NUMBER

Registration District No. 225 Primary Registration District No. 4335 Registrar's No. 7

1. PLACE OF DEATH a. COUNTY <u>Monitern</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Mo.</u> b. COUNTY <u>Monitern</u>			
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Tipton</u>		Length of stay in 1b <u>15 years</u>		c. CITY OR TOWN <u>Tipton</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>Home</u>			Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location)		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <u>Thomas</u> Middle <u>Albert</u> Last <u>Hoys</u>				4. DATE OF DEATH Month <u>Sept.</u> Day <u>23</u> Year <u>1960</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>Cal.</u>	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>		8. DATE OF BIRTH <u>4-3-1878</u>	9. AGE (last birthday) <u>82</u>	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) <u>Farmer</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>Morgan Co., Mo.</u>		12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>		
13a. FATHER'S NAME <u>Ben Hoys</u>			13b. MOTHER'S MAIDEN NAME <u>Rose Newkirk</u>			14. NAME OF HUSBAND OR WIFE <u>Ethel Hoys</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>Ethel Hoys Tipton, Mo.</u> 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) <u>Strangulation due to hanging.</u> DUE TO (b) _____ DUE TO (c) _____ Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.							INTERVAL BETWEEN ONSET AND DEATH <u>10 Min.</u>
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 checked="" type="checkbox"/> HOMICIDE <input type="checkbox"/>	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.) <u>Hung himself.</u>					
20c. TIME OF INJURY <u>10:30 a.m.</u>		Month, Day, Year <u>9-23-60</u>					
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.) <u>Home -</u>		20f. CITY, TOWN, OR LOCATION <u>Tipton</u>		COUNTY <u>Monitern</u>	STATE <u>Mo</u>
21. I attended the deceased from <u>death when first seen</u> and last saw her/him alive on _____ Death occurred at <u>10:30 P.M.</u> on the date stated above, and to the best of my knowledge, from the causes stated.							
22a. SIGNATURE (Degree or title) <u>Keayon Nathan M.D. - Corona California, Mo</u>				22b. ADDRESS <u>Monitern Co., Mo</u>		22c. DATE SIGNED <u>9-24-60</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE <u>25 Sept. 60</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Newkirk Cemetery</u>		23d. LOCATION (City, town, or county) (State) <u>Monitern Co., Mo.</u>			
24. FUNERAL DIRECTOR <u>Kidwell Funeral Home Versailles, Mo.</u>				ADDRESS <u>Sept. 24-60</u>	25. DATE RECD. BY LOCAL REG. <u>Sept. 24-60</u>	26. REGISTRAR'S SIGNATURE <u>Mrs. Maude Hudson</u>	

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. 4021

P. O. Address Versailles

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