

JRI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-60-035755

FILED VS OCT 14 1960

STATE FILE NUMBER

Registration District No. 290 Primary Registration District No. _____ Registrar's No. 133

1. PLACE OF DEATH a. COUNTY Pulaski				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri COUNTY Pulaski				
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Waynesville, Mo (Cullen		Length of stay in 1b 18 years		c. CITY OR TOWN Waynesville, Mo.		Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>		
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Waynesville, Missouri			Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	d. STREET ADDRESS (If outside, give location) General Delivery		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First Margaret. Middle Elizabeth Last Childers.				4. DATE OF DEATH Month Sept. Day 21, Year 1960				
5. SEX Female	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 5/13/1871	9. AGE (last birthday) 89	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) Housewife.			10b. KIND OF BUSINESS OR INDUSTRY -----		11. BIRTHPLACE (City and state or country) Shelbyville, Ind.		12. CITIZEN OF WHAT COUNTRY U.S.A.	
13a. FATHER'S NAME Ruben Arthur.			13b. MOTHER'S MAIDEN NAME Elizabeth Sexton.		13c. NAME OF HUSBAND OR WIFE William F. Childers.			
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. None.		17. INFORMANT Address Missouri Mr. Andrew Childers, Waynesville				
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><i>Acute Cardiac Failure</i></u> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <u><i>Essential Hypertension</i></u> 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						INTERVAL BETWEEN ONSET AND DEATH <u><i>1 da</i></u> <u><i>2 yrs</i></u>		
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 _____ 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 <u><i>9-10-60</i></u> to <u><i>9-21-60</i></u> and last saw her alive on <u><i>9-21-60</i></u> Death occurred at <u><i>1:55</i></u> <u><i>A</i></u> m on the date stated above, and to the best of my knowledge, from the causes stated.								
22a. SIGNATURE (Degree or title) <u><i>E. Miller, M.D.</i></u> M.D.				22b. ADDRESS Waynesville, Missouri		22c. DATE SIGNED 9-21-60		
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 9/23/60	23c. NAME OF CEMETERY OR CREMATORY Hooker Cemetery		23d. LOCATION (City, town, or county) (State) Waynesville, Mo Rural			
24. FUNERAL DIRECTOR <u><i>Walter R. Hedges</i></u> Hedges Funeral Home				ADDRESS Waynesville, Missouri	25. DATE RECD. BY LOCAL REG. 9-22-60		26. REGISTRAR'S SIGNATURE <u><i>Paula Inge Anderson</i></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 Clarence Prose

Licensed Embalmer No. 4896

P. O. Address Waynesville

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.