

IRI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-60-037232

FILED VS. SEP 20 1960

360

6225

197

STATE FILE NUMBER

NDED

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

1. PLACE OF DEATH		2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission)	
a. COUNTY <i>Vernon</i>	Length of stay in 1b <i>31 yrs</i>	a. STATE <i>Mo</i>	b. COUNTY <i>Jasper</i>
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <i>Wash Twp.</i>		c. CITY OR TOWN <i>Joplin</i>	Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <i>St Joseph #3</i>	Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <i>unknown</i>	Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>

3. NAME OF DECEASED (Type or print)			4. DATE OF DEATH			
First <i>Anna</i>	Middle _____	Last <i>Berlin</i>	Month <i>9</i>	Day <i>16</i>	Year <i>60</i>	
5. SEX <i>F</i>	6. COLOR OR RACE <i>White</i>	7. Married <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <i>unknown</i>	9. AGE (last birthday) <i>unknown</i>	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) <i>unknown</i>	10b. KIND OF BUSINESS OR INDUSTRY <i>unknown</i>	11. BIRTHPLACE (City and state or country) <i>Berlin, Mo</i>	12. CITIZEN OF WHAT COUNTRY <i>USA</i>
---	---	---	---

13a. FATHER'S NAME <i>unknown</i>	13b. MOTHER'S MAIDEN NAME <i>unknown</i>	14. NAME OF HUSBAND OR WIFE _____
--------------------------------------	---	--------------------------------------

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <i>No</i>	16. SOCIAL SECURITY NO. <i>unknown</i>	17. INFORMANT <i>Hoop Record</i>	Address _____
---	---	-------------------------------------	------------------

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY:		INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a)	<i>Coronary heart disease</i>	
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	<i>Coronary sclerosis</i>	
DUE TO (b)	<i>Coronary sclerosis</i>	
DUE TO (c)	<i>Sepsis</i>	

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <i>Schizophrenia</i>	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 _____ 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 <i>11-1-59</i> to <i>9-16-60</i> and last saw her/him alive on <i>9-16-60</i>	
Death occurred at <i>5:15</i> m on the date stated above, and to the best of my knowledge, from the causes stated.	

22a. SIGNATURE <i>F L Martin</i>	(Degree or title) <i>M.D.</i>	22b. ADDRESS <i>St Joseph #3</i>	22c. DATE SIGNED <i>9-16-60</i>
-------------------------------------	----------------------------------	-------------------------------------	------------------------------------

23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE <i>9-16-60</i>	23c. NAME OF CEMETERY OR CREMATORY <i>St Louis Missouri</i>	23d. LOCATION (City, town, or county) <i>St Louis Missouri</i>	(State)
---	-----------------------------	--	---	---------

25. DATE RECD. BY LOCAL REG. <i>9-17-1960</i>	26. REGISTRAR'S SIGNATURE <i>Anna E. Jurek</i>
--	---

(Licensed Embalmer's Statement on Reverse Side)

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

State Anatomical Board
Funeral Home
Nevada, Missouri

Dr. Mildred Trotter
4580 Scott Ave.
St. Louis, Mo.

25. DATE RECD. BY LOCAL REG. *9-17-1960*
26. REGISTRAR'S SIGNATURE *Anna E. Jurek*

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 L. Douglas Ferry

Licensed Embalmer No. 4960

P. O. Address Nevada

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.