

# RI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

FILED VS NOV 15 1960

-60-037310

STATE FILE NUMBER

Registration District No. 1 Primary Registration District No. 400 Registrar's No. 325

IDED

1. PLACE OF DEATH				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)			
a. COUNTY <b>Adair</b>		b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>Brashear</b>		a. STATE <b>Mo</b>		b. COUNTY <b>Adair</b>	
Length of stay in 1b <b>life</b>		c. CITY OR TOWN <b>Brashear</b>		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>		Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION				d. STREET ADDRESS (If outside, give location)		Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print)				4. DATE OF DEATH			
First <b>SAMUEL</b>		Middle <b>ELLSWORTH</b>		Last <b>WALTERS</b>		Month Day Year <b>Nov 4, 1960</b>	
5. SEX <b>M</b>	6. COLOR OR RACE <b>W</b>	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <b>4/8/1862</b>	9. AGE (last birthday) <b>98</b>	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) <b>Retired farmer</b>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (City and state or country) <b>Millesburg Co. Ohio</b>		12. CITIZEN OF WHAT COUNTRY <b>USA</b>	
13a. FATHER'S NAME <b>Michael Walters</b>			13b. MOTHER'S MAIDEN NAME <b>Rachel M. Wade</b>			14. NAME OF HUSBAND OR WIFE <b>Nancy Mae Parsons</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>no</b>			16. SOCIAL SECURITY NO.		17. INFORMANT 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) _____							
DUE TO (b) _____							
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		
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.) <b>Self inflicted gunshot wound into the right temple area. ( 12 gauge shot gun)</b>					
20c. TIME OF INJURY Hour Month, Day, Year <b>10:15 a.m. Nov. 4 1960</b>		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.) <b>At Home (residence)</b>		20f. CITY, TOWN, OR LOCATION COUNTY STATE <b>Brashear, Adair, Missouri</b>	
21. I attended the deceased from _____, to _____ and last saw her him alive on _____ Death occurred at <b>10:15 a.m.</b> on the date stated above, and to the best of my knowledge, from the causes stated.							
22a. SIGNATURE <i>Nova E. Foster</i> <b>Nova E. Foster</b> Coroner				22b. ADDRESS <b>Kirkville, Adair, Missouri</b>		22c. DATE SIGNED <b>11/8/60</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>burial</b>		23b. DATE <b>7 Nov '60</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Brashear Cemetery</b>		23d. LOCATION (City, town, or county) (State) <b>Brashear, Missouri</b>	
24. FUNERAL DIRECTOR ADDRESS <b>HUDSON-RIMER FUNERAL HOME Edina, Mo</b>				25. DATE RECD. BY LOCAL REG. <b>11-9-1960</b>		26. REGISTRAR'S SIGNATURE <i>Doris W. Ruff</i>	

(Licensed Embalmer's Statement on Reverse Side)

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 AGP

Licensed Embalmer No. 50

P. O. Address Edina

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.