

RI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-60-037459

FILED VS OCT 17 1960 38

3006

569

STATE FILE NUMBER

1. PLACE OF DEATH a. COUNTY <u>Boone</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Clinton</u>			
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Columbia</u>		Length of stay in lb <u>13 days</u>		c. CITY OR TOWN <u>Cameron</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>Ellis Fischel State Cancer</u>				Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>		d. STREET ADDRESS (If outside, give location) <u>511 West Cornhill</u>	
3. NAME OF DECEASED (Type or print) First <u>Frona</u> Middle <u>Myrtle</u> Last <u>Stinson</u>				4. DATE OF DEATH Month <u>Oct.</u> Day <u>9</u> Year <u>1960</u>			
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</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>12/7/82</u>	9. AGE (last birthday) <u>77</u>	IF UNDER 1 YEAR Months	IF UNDER 24 HR Days	Hours
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>-----</u>		11. BIRTHPLACE (City and state or country) <u>Cameron, Missouri</u>		12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>	
13a. FATHER'S NAME <u>John C. Henderson</u>			13b. MOTHER'S MAIDEN NAME <u>Mary E. Glenn</u>		14. NAME OF HUSBAND OR WIFE <u>Thomas O. Stinson</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>Hospital files</u>			
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 <u>12 hr</u>	
IMMEDIATE CAUSE (a)		<u>Generalized Peritonitis</u>					
DUE TO (b)		<u>Focal contamination</u>					
DUE TO (c)		<u>Necrosis suture line large bowel</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 checked="" 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 <u>24 Sep 60</u> to <u>9 Oct 60</u> and last saw <u>him</u> alive on <u>9 Oct 60</u> Death occurred at <u>4:43</u> <u>P</u> m on the date stated above, and to the best of my knowledge, from the causes stated.							
22a. SIGNATURE <u>[Signature]</u>				(Degree or title) <u>MD</u>		22b. ADDRESS <u>Ellis Fischel Cancer Hosp.</u>	
22c. DATE SIGNED <u>9 Oct.</u>							
23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE <u>Oct 11 1960</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Seacrest</u>		23d. LOCATION (City, town, or county) <u>Cameron</u>		23e. (State) <u>Mo</u>	
24. FUNERAL DIRECTOR <u>Coland Funeral Home</u>				ADDRESS <u>Cameron Mo</u>		25. DATE RECD. BY LOCAL REG. <u>Oct. 9 1960</u>	
				26. REGISTRAR'S SIGNATURE <u>Mrs R.E. Palmer</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
or by _____, Student Embalmer No. _____

working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed Robert F. Polansky

Licensed Embalmer No. 4277

P. O. Address Camecar

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