

JRI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-60-037661

FILED VS. OCT 20 1960

47

Primary Registration District No. 3008

Registrar's No. 278

STATE FILE NUMBER

INDEXED

1. PLACE OF DEATH a. COUNTY <i>Callaway</i>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>MO</i> b. COUNTY <i>Callaway</i>					
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <i>Fulton</i>		Length of stay in 1b <i>3 mo</i>		c. CITY OR TOWN <i>CARRINGTON</i>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>			
c. FULL NAME OF (IF NOT in hospital, give location) HOSPITAL OR INSTITUTION <i>Callaway Memorial Hospital</i>			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 <i>BURTON</i> Middle <i>OLIVER</i> Last <i>NEVINS</i>				4. DATE OF DEATH Month <i>October</i> Day <i>10</i> Year <i>1960</i>					
5. SEX <i>Male</i>		6. COLOR OR RACE <i>Negro</i>		7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>		8. DATE OF BIRTH <i>Aug 11 - 88</i>			
9. AGE (last birthday) <i>72</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>Farmer</i>			10b. KIND OF BUSINESS OR INDUSTRY <i>Retired</i>		11. BIRTHPLACE (City and state or country) <i>Callaway Co Mo.</i>		12. CITIZEN OF WHAT COUNTRY <i>USA.</i>		
13a. FATHER'S NAME <i>Thomas Nevins</i>			13b. MOTHER'S MAIDEN NAME <i>Julia Lynes</i>			14. NAME OF HUSBAND OR WIFE <i>Bessie Nevins</i>			
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>None</i>		17. INFORMANT <i>Owen Nevins New Bloomfield</i>			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) <i>Hem. arterio sclerosis and nutrition</i> DUE TO (b) <i>Fracture of femur & being</i> DUE TO (c) <i>headst. of P. scultatus</i> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)							INTERVAL BETWEEN ONSET AND DEATH		
PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> N. <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 checked="" type="checkbox"/>		20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		20f. CITY, TOWN, OR LOCATION <i>Fulton</i>		COUNTY		STATE	
21. I attended the deceased from <i>July 9 - 1960</i> to <i>Oct. 10/60</i> and last saw him alive on <i>Oct. 10 - 60</i> Death occurred at <i>10:15</i> p.m. on the date stated above, and to the best of my knowledge, from the causes stated.									
22a. SIGNATURE <i>J. H. Lawrence M.D.</i>					22b. ADDRESS <i>Fulton MO</i>			22c. DATE SIGNED <i>10/11/60</i>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		23b. DATE <i>Oct 12 - 60</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Oak Chapel Ceme</i>		23d. LOCATION (City, town, or county) <i>West Fulton</i>		23e. STATE <i>MO</i>	
24. FUNERAL DIRECTOR <i>C. Laypool Service New Bloomfield</i>				ADDRESS		25. DATE RECD. BY LOCAL REG. <i>Oct. 11 - 1960</i>		26. REGISTRAR'S SIGNATURE <i>Martha Lawrence</i>	

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

OCT 1 1960

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 LeRoy Claypool

Licensed Embalmer No. 4412

P. O. Address New Bloomfield

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.