

# R.I. DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

FILED VS OCT 17 1960

60-038206

STATE FILE NUMBER

Registration District No. 140 Primary Registration District No. 5549 Registrar's No. 94

1. PLACE OF DEATH				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)			
a. COUNTY <b>Howard</b>		b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>Richmond</b>		a. STATE <b>Missouri</b> b. COUNTY <b>Howard</b>		c. CITY OR TOWN <b>Fayette</b>	
Length of stay in 1b <b>20 years</b>		Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>		d. STREET ADDRESS (If outside, give location) <b>R. R. #2 Fayette</b>		Reside on Farm Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>Anna Eula McCutcheon</b>				4. DATE OF DEATH <b>Oct. 11 1960</b>			
5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>		7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>		8. DATE OF BIRTH <b>5/7/1891</b>	
9. AGE (last birthday) <b>69</b>		IF UNDER 1 YEAR Months Days		IF UNDER 24 HR Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of last year, or when if retired) <b>Housework</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Own Home</b>		11. BIRTHPLACE (City and state or country) <b>Cooper Co. Mo.</b>		12. CITIZEN OF WHAT COUNTRY <b>U.S.A.</b>	
13a. FATHER'S NAME <b>Charles Oglesby</b>			13b. MOTHER'S MAIDEN NAME <b>Eva Ellen Cordry</b>			14. NAME OF HUSBAND OR WIFE <b>Charles E. McCutcheon</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. <b>None</b>		17. INFORMANT <b>Charles E. McCutcheon Fayette Mo</b>			
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) <b>pulmonary edema</b>						<b>months</b>	
DUE TO (b) <b>carcinomatosis</b>						<b>6 month</b>	
DUE TO (c) <b>carcinoma of colon</b>						<b>1 year</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <b>none</b>						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 checked="" 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.) <b>none</b>			
20c. TIME OF INJURY Hour a.m. p.m. <b>✓</b>		Month, Day, Year <b>✓</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.)		20f. CITY, TOWN, OR LOCATION		COUNTY STATE	
21. I attended the deceased from <b>August, 1960</b> to <b>Oct 11, 1960</b> and last saw her/him <b>Dead on 10-11-60</b>							
Death occurred at <b>4 P.M.</b> on the date stated above, and to the best of my knowledge, from the causes stated.							
22a. SIGNATURE (Degree or title) <b>Dr. J. Shaw Jr M.D.</b>				22b. ADDRESS <b>Lee Hospital, Fayette, Mo.</b>		22c. DATE SIGNED <b>10-12-60</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE <b>10/13/60</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Pilot Grove Cem.</b>		23d. LOCATION (City, town, or county) (State) <b>Pilot Grove Mo.</b>	
24. FUNERAL DIRECTOR <b>Ralph A. Carr Fayette Mo.</b>				25. DATE RECD. BY LOCAL REG. <b>10-12-60</b>		26. REGISTRAR'S SIGNATURE <b>Katherine Welch</b>	

DED

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

MAR 1 1961

MAR 1 1961

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by

on by \_\_\_\_\_, Student Embalmer No. \_\_\_\_\_

working under my personal supervision.

Student \_\_\_\_\_

Signature of Student Embalmer

Signed William E. Grebe

Licensed Embalmer No. 4870

P. O. Address Fayette

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.