

RI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-60-038215

FILED VS OCT 24 1960

STATE FILE NUMBER

Registration District No. 141 Primary Registration District No. 3085 Registrar's No. 146

1. PLACE OF DEATH a. COUNTY <u>Warren</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Mo</u> b. COUNTY <u>Warren</u>									
b. CITY (If outside corporate limits give TOWNSHIP only) OR TOWN <u>West Plains Mo</u>		Length of stay in 1b <u>1 1/2</u>		c. CITY OR TOWN <u>West Plains</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>915 W 1st</u>			Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location) <u>540 E Cleveland</u>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>						
3. NAME OF DECEASED (Type or print) First <u>Mary Dorcas</u> Middle <u>Jarard</u> Last <u>Jarard</u>				4. DATE OF DEATH Month <u>10</u> - Day <u>10</u> - Year <u>60</u>									
5. SEX <u>F</u>		6. COLOR OR RACE <u>W</u>		7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>		8. DATE OF BIRTH <u>9-74</u>		9. AGE (last birthday) <u>86</u>		IF UNDER 1 YEAR Months <u>0</u> Days <u>0</u> Hours <u>0</u> Min. <u>0</u>		IF UNDER 24 HR Hours <u>0</u> Min. <u>0</u>	
10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>				10b. KIND OF BUSINESS OR INDUSTRY <input checked="" type="checkbox"/>		11. BIRTHPLACE (City and state or country) <u>Summersville Mo</u>		12. CITIZEN OF WHAT COUNTRY <u>USA</u>					
13a. FATHER'S NAME <u>M.A. Kaedolph</u>				13b. MOTHER'S MAIDEN NAME <u>Lidia</u>				14. NAME OF HUSBAND OR WIFE <u>Edw Jarard, West Plains Mo</u>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <u>1-10-10-10-10</u>		17. INFORMANT <u>Edw Jarard, West Plains Mo</u>		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) <u>Congestive Heart Failure</u>								INTERVAL BETWEEN ONSET AND DEATH <u>2 hrs</u>					
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.		DUE TO (b) <u>Pulmonary Edema</u>						<u>6 hrs</u>					
		DUE TO (c) <u>Arteriosclerotic Heart Disease</u>						<u>10 yrs</u>					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>Pyelonephritis</u>								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 <u>11:30</u> 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		COUNTY		STATE					
21. I attended the deceased from <u>July 15 1960</u> to <u>10-10-60</u> and last saw her <u>live</u> on <u>10-10-60</u> Death occurred at <u>7:30</u> on the date stated above, and to the best of my knowledge, from the causes stated.													
22a. SIGNATURE <u>Murray J. Pritchard</u> (Degree or title)				22b. ADDRESS <u>913 W. Main West Plains Mo.</u>				22c. DATE SIGNED <u>10-15-60</u>					
23a. BURIAL, CREMATION, REBURY (Specify)		23b. DATE <u>10/12-60</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Summersville</u>				23d. LOCATION (City, town, or county) (State) <u>Summersville Mo</u>					
24. FUNERAL DIRECTOR <u>Cobertson</u>		ADDRESS <u>West Plains Mo</u>		25. DATE RECD. BY LOCAL REG. <u>10-19-60</u>		26. REGISTRAR'S SIGNATURE <u>Beatrice Cook</u>							

(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 _____, Student Embalmer No. _____

or by _____, _____
working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed *D. S. Roberts*

Licensed Embalmer No. 343

P. O. Address *Leesville*

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.