

RI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-60-038633

FILED VS NOV 15 1960 /46

Registration District No. 3026 Primary Registration District No. 3026 Registrar's No. 527

STATE FILE NUMBER

DED

1. PLACE OF DEATH a. COUNTY Jackson				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Mo. b. COUNTY Jackson				
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Independence		Length of stay in 1b 50 yrs.		c. CITY OR TOWN Independence		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Indep. Hospital			Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location) 421 W. Farmer		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) MR. JOSHUA LARKIN DANIEL				4. DATE OF DEATH Month October Day 27 , Year 1960				
5. SEX Male	6. COLOR OR RACE White	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>		8. DATE OF BIRTH Sept. 26, 1885	9. AGE (last birthday) 75	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) Retired-Laundry Salesman			10b. KIND OF BUSINESS OR INDUSTRY Salesman		11. BIRTHPLACE (City and state or country) Maysville, Mo.		12. CITIZEN OF WHAT COUNTRY USA	
13a. FATHER'S NAME Jonathan Daniel			13b. MOTHER'S MAIDEN NAME Rebecca Daniel			14. NAME OF HUSBAND OR WIFE Rose Daniel		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 492-38-8358		17. INFORMANT Mrs. Rose Daniel		Address 421 W. Farmer, Indep., Mo.		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic Heart Disease DUE TO (b) Generalized Arteriosclerosis DUE TO (c) Chronic Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.							INTERVAL BETWEEN ONSET AND DEATH Chronic	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) Multiple Cerebrovascular accidents Bronchopneumonia						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 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 Oct 22, 1949 to Oct 27, 1960 and last saw her/him alive on Oct 27, 1960 Death occurred at 5:00 A m on the date stated above, and to the best of my knowledge, from the causes stated.								
22a. SIGNATURE W. H. Hickerson MD				(Degree or title)		22b. ADDRESS 604 W. Maple Independence, Mo		22c. DATE SIGNED 10/27/60
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE Oct. 30, 1960	23c. NAME OF CEMETERY OR CREMATORY New Salem Cemetery			23d. LOCATION (City, town, or county) (State) E. of Indep. on 24 highway		
24. FUNERAL DIRECTOR OTT & MITCHELL, Indep., Mo.				ADDRESS		25. DATE RECD. BY LOCAL REG. Oct. 30. 60		26. REGISTRAR'S SIGNATURE James H. [Signature]

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 Henry J. Mitchel

Licensed Embalmer No. 372

P. O. Address Independence

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.