

JRI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-60-039166

FILED VS OCT 3 1 1960

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STATE FILE NUMBER

Registration District No. \_\_\_\_\_ Primary Registration District No. \_\_\_\_\_ Registrar's No. \_\_\_\_\_

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|---|--|--|--|
| 1. PLACE OF DEATH<br>a. COUNTY <u>Nodaway</u>                                   |  | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)<br>a. STATE <u>Mo</u> b. COUNTY <u>Nodaway</u> |  |
| b. CITY (If outside corporate limits, give TOWNSHIP only)<br><u>Marionville</u> |  | Length of stay in 1b<br><u>3 wks</u>   | c. CITY OR TOWN <u>Guilford</u> Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>                           |
| c. FULL NAME OF HOSPITAL OR INSTITUTION <u>St. Francis Hosp</u>                 |  | Inside Limits Yes <input 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"/> |

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|---|--|--|---------------------------------------|--|--|--|
| 3. NAME OF DECEASED (Type or print)<br>First <u>Stella</u> Middle _____ Last <u>Wales</u> |  |  | 4. DATE OF DEATH<br><u>10-10-1960</u> |  |  |  |
|---|--|--|---------------------------------------|--|--|--|

|                      |                              |  |                                  |                                  |  |  |
|----------------------|------------------------------|--|----------------------------------|----------------------------------|--|--|
| 5. SEX <u>Female</u> | 6. COLOR OR RACE <u>Cau.</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>3-2-1888</u> | 9. AGE (last birthday) <u>75</u> | IF UNDER 1 YEAR<br>Months _____ Days _____ | IF UNDER 24 HR<br>Hours _____ Min. _____ |
|----------------------|------------------------------|--|----------------------------------|----------------------------------|--|--|

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| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><u>house wife</u> | 10b. KIND OF BUSINESS OR INDUSTRY<br><u>own home</u> | 11. BIRTHPLACE (City and state or country)<br><u>Bolekov, Mo</u> | 12. CITIZEN OF WHAT COUNTRY<br><u>USA</u> |
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|--|--|---|
| 13a. FATHER'S NAME<br><u>Madison Nolan</u> | 13b. MOTHER'S MAIDEN NAME<br><u>Belle Cunningham</u> | 14. NAME OF HUSBAND OR WIFE<br><u>Harmon D. Wales</u> |
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| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)<br><u>No.</u> | 16. SOCIAL SECURITY NO.<br><u>491-28-102</u> | 17. INFORMANT<br><u>Mrs. Mary E. Wade - Spokane, Wash</u> |
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| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>uremia.</u> |                  | INTERVAL BETWEEN ONSET AND DEATH<br><u>14 day</u> |
| Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.   | DUE TO (b) _____ |   |
|  | DUE TO (c) _____ |   |

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| 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.<br><input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown |
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| 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.) |
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|---|
| 20c. TIME OF INJURY<br>Hour _____ a.m. _____ p.m. _____<br>Month, Day, Year _____ |
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|  |  |  |
|--|--|--|
| 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<br>COUNTY _____ STATE _____ |
|--|--|--|

21. I attended the deceased from 9-20-60 to 10-10-60 and last saw her alive on 10-10-60  
Death occurred at 12:20 on the date stated above, and to the best of my knowledge, from the causes stated.

|  |                                       |                                     |
|--|---------------------------------------|-------------------------------------|
| 22a. SIGNATURE<br><u>[Signature]</u> (Degree or title) | 22b. ADDRESS<br><u>Marionville Mo</u> | 22c. DATE SIGNED<br><u>10-15-60</u> |
|--|---------------------------------------|-------------------------------------|

|  |                              |   |   |
|--|------------------------------|---|---|
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><u>Burial</u> | 23b. DATE<br><u>10-12-60</u> | 23c. NAME OF CEMETERY OR CREMATORY<br><u>Graves Cem</u> | 23d. LOCATION (City, town, or county) (State)<br><u>Guilford Mo</u> |
|--|------------------------------|---|---|

|  |                                  |   |   |
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| 24. FUNERAL DIRECTOR<br><u>Atchison Funeral Home</u> | ADDRESS<br><u>Marionville Mo</u> | 25. DATE RECD. BY LOCAL REG.<br><u>10-22-60</u> | 26. REGISTRAR'S SIGNATURE<br><u>Bess Holt</u> |
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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 G M Akhisa

Licensed Embalmer No. 227

P. O. Address Mongu

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.