

FRI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-60-039263

FILED VS. OCT 20 1960

Registration District No. 275 Primary Registration District No. 3053 Registrar's No. 198 STATE FILE NUMBER

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| 1. PLACE OF DEATH a. COUNTY Phelps | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY Franklin | |
| b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Rolla | | Length of stay in 1b 4 years | c. CITY OR TOWN St. Clair Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> |
| c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION McFarland Nursing Home | | Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> | d. STREET ADDRESS (If outside, give location) None Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> |

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|---|----------------------------------|---|--|--|---|
| 3. NAME OF DECEASED (Type or print) First Middle Last MARGARET COLEMAN | | | 4. DATE OF DEATH Month Day Year October 11, 1960 | | |
| 5. SEX Female | 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 3/6/86 | 9. AGE (last birthday) 74 | IF UNDER 1 YEAR Months Days Hours Min. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife | | 10b. KIND OF BUSINESS OR INDUSTRY None | 11. BIRTHPLACE (City and state or country) Macon, Missouri | 12. CITIZEN OF WHAT COUNTRY U.S.A. | |

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| 13a. FATHER'S NAME Jefferson White | 13b. MOTHER'S MAIDEN NAME C. Rice | 14. NAME OF HUSBAND OR WIFE Charles |
| 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. None | 17. INFORMANT Address Nursing Home Records |

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| 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>Cerebral Anemia</u> | | INTERVAL BETWEEN ONSET AND DEATH <u>1 wks.</u> |
| Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <u>an advanced arterio-sclerosis</u> 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. <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.) | |
| 20c. TIME OF INJURY Hour a.m. p.m. 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 | COUNTY | STATE |
| 21. I attended the deceased from <u>6/20/56</u> to <u>10/11/60</u> and last saw her <u>him</u> alive on <u>10/10/60</u> . Death occurred at <u>9 A.</u> on the date stated above, and to the best of my knowledge, from the causes stated. | | | | |

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|---|-----------------------------------|--|---|-------------------------------------|
| 22a. SIGNATURE <i>James M. Nye</i> (Degree or title) <u>MD</u> | | 22b. ADDRESS <u>Rolla Mo</u> | | 22c. DATE SIGNED <u>10/13/60</u> |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Removal | 23b. DATE Oct. 11, 1960 | 23c. NAME OF CEMETERY OR CREMATORY Friedens Cemetery | 23d. LOCATION (City, town, or county) St. Louis, Missouri | |
| 24. FUNERAL DIRECTOR ADDRESS By <i>Paul E. Null</i> Null & Son Funeral Home Rolla | | 25. DATE RECD. BY LOCAL REG. Oct. 11, 1960 | 26. REGISTRAR'S SIGNATURE <i>Nadene L. Stoll</i> | |

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

OCT 20 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 Paul E. New

Licensed Embalmer No. 4498

P. O. Address Rolla, Mo.

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.