

RI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-60-039416

FILED VS NOV 14 1960

STATE FILE NUMBER

Registration District No. 314 Primary Registration District No. 4459 Registrar's No. \_\_\_\_\_

DED

1. PLACE OF DEATH		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)	
a. COUNTY <u>ST CLAIR</u>	a. STATE <u>MISSOURI</u>	b. COUNTY <u>ST CLAIR</u>	b. COUNTY <u>ST CLAIR</u>
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>OSCEOLA</u>	Length of stay in 1b <u>50 yr</u>	c. CITY OR TOWN <u>OSCEOLA</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>OSCEOLA HOSPITAL</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 type="checkbox"/>

3. NAME OF DECEASED (Type or print)			4. DATE OF DEATH	
First <u>ROY</u>	Middle <u>-</u>	Last <u>HENRY</u>	Month <u>OCT</u>	Day <u>29</u> Year <u>1960</u>
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. Married <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <u>5-21-91 69</u>	9. AGE (last birthday) <u>69</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>MASON</u>	10b. KIND OF BUSINESS OR INDUSTRY <u>Building</u>	11. BIRTHPLACE (City and state or country) <u>Collins MO USA</u>	12. CITIZEN OF WHAT COUNTRY <u>USA</u>	
13a. FATHER'S NAME <u>Haymond Henry</u>	13b. MOTHER'S MAIDEN NAME <u>Laura McGown</u>	14. NAME OF HUSBAND OR WIFE _____		

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>Yes WW#1</u>	16. SOCIAL SECURITY NO. <u>491-32-8329</u>	17. INFORMANT <u>John Henry, Osceola MO</u>	Address _____
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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:		INTERVAL BETWEEN ONSET AND DEATH <u>2 yr</u>
IMMEDIATE CAUSE (a) <u>Carcinoma of lung</u>		
DUE TO (b) _____		
DUE TO (c) _____		
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

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 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 10-10-60 to 10-30-60 and last saw him alive on 10-28-60  
 Death occurred at 7:00 a.m. on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE <u>Paul Seewers MD</u> (Degree or title)	22b. ADDRESS <u>Osceola MO</u>	22c. DATE SIGNED <u>10-30-60</u>
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE <u>10-31-60</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Osceola</u>
24. FUNERAL DIRECTOR <u>Goodrich J. Home</u>	ADDRESS <u>Osceola MO</u>	25. DATE RECD. BY LOCAL REG. <u>11-4-60</u>
26. REGISTRAR'S SIGNATURE <u>Paul Seewers</u>		

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

DEC 7 1950

**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 D. Stone*

Licensed Embalmer No. 3990

P. O. Address Oscar

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.