

# DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

FILED VS NOV 9 1960

-60-039473

STATE FILE NUMBER

Registration District No. 316 Primary Registration District No.      Registrar's No. 432

1. PLACE OF DEATH a. COUNTY <b>ST FRANCOIS</b>			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MISSOURI</b> b. COUNTY <b>ST FRANCOIS</b>					
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>FARMINGTON - Rural</b>		Length of stay in 1b <b>5 Yrs.</b>	c. CITY OR TOWN <b>FARMINGTON</b>		Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>			
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>RT. 2</b>		Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <b>RT. 2</b>		Reside on Farm Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>ROY</b> Middle <b>GEAN</b> Last <b>VALLE</b>			4. DATE OF DEATH Month <b>OCT.</b> Day <b>31</b> Year <b>1960</b>					
5. SEX <b>MALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <b>1/12/12</b>	9. AGE (last birthday) <b>48</b>	IF UNDER 1 YEAR Months <input type="checkbox"/> Days <input type="checkbox"/>		IF UNDER 24 HR Hours <input type="checkbox"/> Min. <input type="checkbox"/>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>MECHANIC</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>GARAGE</b>		11. BIRTHPLACE (City and state or country) <b>GLEN PARK MO.</b>		12. CITIZEN OF WHAT COUNTRY <b>U.S.A.</b>		
13a. FATHER'S NAME <b>THOMAS VALLE</b>			13b. MOTHER'S MAIDEN NAME <b>MAY CARTER</b>		14. NAME OF HUSBAND OR WIFE <b>MARTHA WILKERSON VALLE</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>YES TWO</b>			16. SOCIAL SECURITY NO. <b>488-18-2670</b>		17. INFORMANT Address <b>Mrs ROY VALLE FARMINGTON MO. RT.2</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Pulmonary Edema</b> DUE TO (b) <b>Carcinoma of the lungs. -</b> DUE TO (c) <b>12 months</b> Interval between ONSET AND DEATH <b>4 days</b>								
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 <input type="checkbox"/> s.m. <input type="checkbox"/> p.m. <input type="checkbox"/> 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 <b>Oct 27, 60</b> to <b>Oct 31, 60</b> and last saw <sup>him</sup> alive on <b>Oct 27-60</b> Death occurred at <b>5:00 AM</b> m on the date stated above, and to the best of my knowledge, from the causes stated.								
22a. SIGNATURE (Degree or title) <i>[Signature]</i> <b>D.O.</b>				22b. ADDRESS <b>Farmington - Mo.</b>		22c. DATE SIGNED <b>11-1-60</b>		
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		23b. DATE <b>11/2/60</b>	23c. NAME OF CEMETERY OR CREMATORY <b>MASONIC</b>		23d. LOCATION (City, town, or county) (State) <b>NEAR BLACKWELL MO.</b>			
24. FUNERAL DIRECTOR <b>C.H.COZEAN FARMINGTON MO.</b>			25. DATE RECD. BY LOCAL REG. <b>Nov. 1, 1960</b>		26. REGISTRAR'S SIGNATURE <i>[Signature]</i>			

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

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NOV 15 1960 .

MAY 23 1967

**STATEMENT BY LICENSED EMBALMER**

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed  
or by \_\_\_\_\_, Student Embalmer No. \_\_\_\_\_

working under my personal supervision.

Student \_\_\_\_\_  
Signature of Student Embalmer

Signed \_\_\_\_\_  
*[Handwritten Signature]*

Licensed Embalmer No. \_\_\_\_\_  
*409*

P. O. Address \_\_\_\_\_  
*[Handwritten Address]*

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.