

U.S. DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

FILED VS OCT 17 1960

-60-040688

STATE FILE NUMBER

Registration District No. 324 Primary Registration District No. 3072 Registrar's No. 183

ENDED

|                                                                             |                                                                     |                                                                                       |                                                                     |
|-----------------------------------------------------------------------------|---------------------------------------------------------------------|---------------------------------------------------------------------------------------|---------------------------------------------------------------------|
| 1. PLACE OF DEATH                                                           |                                                                     | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) |                                                                     |
| a. COUNTY                                                                   | <u>Saline</u>                                                       | a. STATE                                                                              | b. COUNTY                                                           |
| b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN           | <u>Marshall</u>                                                     | <u>Missouri</u>                                                                       | <u>Saline</u>                                                       |
| Length of stay in 1b                                                        |                                                                     | c. CITY OR TOWN                                                                       | Inside Limits                                                       |
| <u>14 hrs</u>                                                               |                                                                     | <u>Sweet Springs</u>                                                                  | Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> |
| c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION | Inside Limits                                                       | d. STREET ADDRESS (If outside, give location)                                         | Reside on Farm                                                      |
| <u>Fitzgibbons</u>                                                          | Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> | <u>103 Revis st</u>                                                                   | Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> |

|                                     |               |                 |                 |                  |           |             |      |
|-------------------------------------|---------------|-----------------|-----------------|------------------|-----------|-------------|------|
| 3. NAME OF DECEASED (Type or print) | First         | Middle          | Last            | 4. DATE OF DEATH | Month     | Day         | Year |
| <u>Madine</u>                       | <u>Madine</u> | <u>Menegali</u> | <u>Menegali</u> | <u>Oct</u>       | <u>14</u> | <u>1960</u> |      |

|               |                  |                                                                                                                                                          |                     |                        |                 |                |
|---------------|------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------|------------------------|-----------------|----------------|
| 5. SEX        | 6. COLOR OR RACE | 7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/> | 8. DATE OF BIRTH    | 9. AGE (last birthday) | IF UNDER 1 YEAR | IF UNDER 24 HR |
| <u>Female</u> | <u>White</u>     |                                                                                                                                                          | <u>Sept 6, 1896</u> | <u>64</u>              | Months          | Days           |
|               |                  |                                                                                                                                                          |                     |                        |                 | Hours          |
|               |                  |                                                                                                                                                          |                     |                        |                 | Min.           |

|                                                                                             |                                   |                                            |                             |
|---------------------------------------------------------------------------------------------|-----------------------------------|--------------------------------------------|-----------------------------|
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10b. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (City and state or country) | 12. CITIZEN OF WHAT COUNTRY |
| <u>house wife</u>                                                                           | <u>none</u>                       | <u>Sweet Springs Mo</u>                    | <u>U.S.A.</u>               |

|                      |                           |                             |
|----------------------|---------------------------|-----------------------------|
| 13a. FATHER'S NAME   | 13b. MOTHER'S MAIDEN NAME | 14. NAME OF HUSBAND OR WIFE |
| <u>Harbert Payne</u> | <u>Mannie Haggard</u>     | <u>Louis Menegali</u>       |

|                                                                                                          |                         |                              |                          |
|----------------------------------------------------------------------------------------------------------|-------------------------|------------------------------|--------------------------|
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO. | 17. INFORMANT                | Address                  |
| <u>no</u>                                                                                                | <u>497-42-5983</u>      | <u>Mrs. Wilbert Fischer,</u> | <u>Sweet Springs Mo.</u> |

|                                                                                                          |            |                                  |
|----------------------------------------------------------------------------------------------------------|------------|----------------------------------|
| 18. CAUSE OF DEATH (Enter only one cause per line for PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) - |            | INTERVAL BETWEEN ONSET AND DEATH |
| <u>Respiratory Insufficiency</u>                                                                         |            |                                  |
| <u>Comp of Pancreas to Gross Metastasis (Cancer)</u>                                                     |            |                                  |
| Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.               | 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 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      | Month, Day, Year |
|                     | a.m. p.m. |                  |

|                                                                                                        |                                                                                          |                              |        |       |
|--------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------|------------------------------|--------|-------|
| 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 Aug 60 to Oct 14 and last saw him alive on Oct 14, 1960  
 Death occurred at \_\_\_\_\_ m on the date stated above, and to the best of my knowledge, from the causes stated.

|                                  |                       |                  |
|----------------------------------|-----------------------|------------------|
| 22a. SIGNATURE (Degree or title) | 22b. ADDRESS          | 22c. DATE SIGNED |
| <u>W Marshall MO.</u>            | <u>W Marshall MO.</u> | <u>10-16-60</u>  |

|                                           |                     |                                    |                                               |
|-------------------------------------------|---------------------|------------------------------------|-----------------------------------------------|
| 23a. BURIAL, CREMATION, REMOVAL (Specify) | 23b. DATE           | 23c. NAME OF CEMETERY OR CREMATORY | 23d. LOCATION (City, town, or county) (State) |
| <u>BURIAL</u>                             | <u>Oct 16, 1960</u> | <u>Fairview Cemetery</u>           | <u>Sweet Springs, MO</u>                      |

|                              |                         |                              |                           |
|------------------------------|-------------------------|------------------------------|---------------------------|
| 24. FUNERAL DIRECTOR         | ADDRESS                 | 25. DATE RECD. BY LOCAL REG. | 26. REGISTRAR'S SIGNATURE |
| <u>Moseley Funeral Home,</u> | <u>Sweet Springs Mo</u> | <u>10-15-60</u>              | <u>Carl A. Reed</u>       |

(Licensed Embalmer's Statement on Reverse Side)

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 me  
or by \_\_\_\_\_, Student Embalmer No. \_\_\_\_\_  
working under my personal supervision.

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

Signed Edgar L. Moseley

Licensed Embalmer No. 4711

P. O. Address Sweet Springs

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.