

# JRI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-60-040833

FILED VS OCT 18 1960

360

6225

215

STATE FILE NUMBER

INDEXED

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

1. PLACE OF DEATH a. COUNTY <u>Vernon</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Mo</u> b. COUNTY <u>Greene</u>				
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Washington Twp</u>		Length of stay in 1b <u>2 1/2 hrs</u>		c. CITY OR TOWN <u>Springfield</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>No. State Hosp. # 3</u>			Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>		d. STREET ADDRESS (If outside, give location) <u>650 S. Weller</u>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Maud</u> Middle <u>Graham</u> Last <u>Hickman</u>				4. DATE OF DEATH Month <u>10</u> Day <u>6</u> Year <u>60</u>				
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>		8. DATE OF BIRTH <u>11-7-1882</u>	9. AGE (last birthday) <u>78</u>	IF UNDER 1 YEAR Months _____ Days _____	IF UNDER 24 HR Hours _____ Min. _____	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Piano Teacher</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>unk</u>		11. BIRTHPLACE (City and state or country) <u>Kansas City Mo</u>		12. CITIZEN OF WHAT COUNTRY <u>USA</u>	
13a. FATHER'S NAME <u>Wallace W. Graham</u>			13b. MOTHER'S MAIDEN NAME <u>Idella Jones</u>			14. NAME OF HUSBAND OR WIFE <u>Ray Curtis Hickman</u>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>unk</u>			16. SOCIAL SECURITY NO. <u>unk</u>		17. INFORMANT <u>Records State Hosp # 3</u>			Address <u>Nevada Mo</u>
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>Bacterial Sclerotic Cardiovascular Disease</u>							INTERVAL BETWEEN ONSET AND DEATH <u>on or before 8-26-60</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) <u>Chr. Brain Syndrome Associated to Dementia</u>						PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input checked="" 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 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>August 1, 1959</u> to <u>Oct 6, 1960</u> and last saw her <sup>her</sup> <sub>him</sub> alive on <u>Oct 5, 1960</u> Death occurred at <u>7:30</u> <u>A</u> m on the date stated above, and to the best of my knowledge, from the causes stated.								
22a. SIGNATURE <u>J. H. Couls</u>				(Degree or title) <u>MD</u>		22b. ADDRESS <u>Nevada Mo</u>		22c. DATE SIGNED <u>10/6/60</u>
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>		23b. DATE <u>10/ 6/ 60</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Elmwood</u>		23d. LOCATION (City, town, or county) (State) <u>Kansas City, Missouri</u>			
24. FUNERAL DIRECTOR <u>Stine &amp; McClure. Kansas City, Mo.</u>				ADDRESS		25. DATE RECD. BY LOCAL REG. <u>10/6/60</u>	26. REGISTRAR'S SIGNATURE <u>Anna E. ?</u>	

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

OCT 19 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 *Lloyd C. McLeod*

Licensed Embalmer No. 4853

P. O. Address *Florida 71*

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to conform 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.