

JRI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-60-040836

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STATE FILE NUMBER

Registration District No. _____ Primary Registration District No. _____ Registrar's No. _____

1. PLACE OF DEATH a. COUNTY <u>VERNON</u> b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>WASHINGTON TOWNSHIP</u> Length of stay in 1b <u>18 DAYS</u> c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>STATE HOSP. #3 NEVADA MO</u> Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MISSOURI</u> b. COUNTY <u>CEYAR</u> c. CITY OR TOWN <u>ELDORADO SPRINGS</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> d. STREET ADDRESS _____ (If outside, give location) Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>CLARENCE</u> Middle <u>-</u> Last <u>MILBOURNE</u>			4. DATE OF DEATH Month <u>OCTOB.</u> Day <u>25</u> Year <u>1960</u>				
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <u>MAY 12 1872</u>	9. AGE (last birthday) <u>88</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>UNKNOWN</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>UNKNOWN</u>		11. BIRTHPLACE (City and state or country) <u>FULTON MISSOURI</u>		12. CITIZEN OF WHAT COUNTRY <u>U.S.A</u>	
13a. FATHER'S NAME _____			13b. MOTHER'S MAIDEN NAME _____		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>NO</u>		16. SOCIAL SECURITY NO. _____		17. INFORMANT <u>HOSP. RECORDS, STATE HOSP. NEVADA MO</u> Address _____			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH CAUSED BY: IMMEDIATE CAUSE (a) <u>BRONCHOPNEUMONIA</u> DUE TO (b) _____ DUE TO (c) _____ Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.					INTERVAL BETWEEN ONSET AND DEATH <u>1 WEEK</u>		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (e) <u>GENERALIZED ART. SCLEROSIS - YEARS</u>					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 checked="" 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 _____		(This area is crossed out with a large diagonal line)					
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>OCT. 7 1960</u> to <u>OCT. 25</u> and last saw her/him alive on <u>OCT. 25 1960</u> Death occurred at <u>7:40 P.M.</u> on the date stated above, and to the best of my knowledge, from the causes stated.							
22a. SIGNATURE <u>George Esker M.D.</u> (Degree or title)			22b. ADDRESS <u>STATE HOSP. NEVADA, MO</u>		22c. DATE SIGNED <u>OCT. 25 1960</u>		
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE <u>10-26-60</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Washington University</u>		23d. LOCATION (City, town, or county) <u>St. Louis, Mo.</u>		
24. FUNERAL DIRECTOR <u>Richard A. Shorten, Nevada, Mo.</u> ADDRESS _____			25. DATE RECD. BY LOCAL REG. <u>10-26-1960</u>		26. REGISTRAR'S SIGNATURE <u>(Signature)</u>		

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 _____
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, Fla.*

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.