

IRI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-60-040976

FILED VS NOV 18 1960

STATE FILE NUMBER

Registration District No. 27 Primary Registration District No. 3005 Registrar's No. 129

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| 1. PLACE OF DEATH a. COUNTY <u>Bates</u> | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Bates</u> | |
| b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Butler</u> | | Length of stay in 1b <u>One Hour</u> | c. CITY OR TOWN <u>Adrian</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>Bates Co. Memorial Hosp</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 type="checkbox"/> |

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| 3. NAME OF DECEASED (Type or print) First <u>Ralph</u> Middle <u>Sherman</u> Last <u>Champ Sr.</u> | | | 4. DATE OF DEATH Month <u>November</u> Day <u>8</u> Year <u>1960</u> | | | |
| 5. SEX <u>Male</u> | 6. COLOR OR RACE <u>White</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>2-13-88</u> | 9. AGE (last birthday) <u>72</u> | IF UNDER 1 YEAR Months <u> </u> Days <u> </u> | IF UNDER 24 HR Hours <u> </u> Min. <u> </u> |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Ret. Farmer</u> | | 10b. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (City and state or country) <u>Howard, Kansas</u> | | 12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u> |
| 13a. FATHER'S NAME <u>Edward Abraham Champ</u> | | 13b. MOTHER'S MAIDEN NAME <u>Theresa Elizabeth Christmas</u> | | 14. NAME OF HUSBAND OR WIFE <u>Alva L. Champ</u> | | |
| 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. <u>486-26-4853</u> | | 17. INFORMANT Address <u>Mrs. Alva L. Champ, Adrian, Mo.</u> | | |

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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: IMMEDIATE CAUSE (a) <u>Ventricular Fibrillation</u> | | INTERVAL BETWEEN ONSET AND DEATH |
| Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. | DUE TO (b) <u>Myocardial Infarction</u> | |
| | DUE TO (c) <u>Hypertensive heart disease</u> | |
| 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 |

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| 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 <u> </u> a.m. <u> </u> p.m. <u> </u> | 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 11-8-60 to 11-8-60 and last saw him alive on 11-8-60
Death occurred at 11-8-60 1:25 A.M. on the date stated above, and to the best of my knowledge, from the causes stated.

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| 22a. SIGNATURE <u>R.L. Hanson</u> (Degree or title) | | 22b. ADDRESS <u>Butler Mo</u> | | 22c. DATE SIGNED <u>11-9-60</u> |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u> | 23b. DATE <u>11-10-60</u> | 23c. NAME OF CEMETERY OR CREMATORY <u>Floral Hills</u> | | 23d. LOCATION (City, town, or county) (State) <u>Kansas City Mo.</u> |

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| 24. FUNERAL DIRECTOR ADDRESS <u>Six Funeral Service, Adrian, Mo.</u> | 25. DATE RECD. BY LOCAL REG. <u>Nov-9-1960</u> | 26. REGISTRAR'S SIGNATURE <u>Renell Koway</u> |
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(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
or by _____, Student Embalmer No. _____
working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed _____ 

Licensed Embalmer No. 3650

P. O. Address Adrian, Mo

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.