

# RI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

FILED VS DEC 6 1960 70

-60-041362  
STATE FILE NUMBER

Registration District No. \_\_\_\_\_ Primary Registration District No. \_\_\_\_\_ Registrar's No. 50

<b>1. PLACE OF DEATH</b> a. COUNTY <u>Clark</u> b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Madison Twnshp.</u> Length of stay in 1b <u>2 yrs</u>		<b>2. USUAL RESIDENCE</b> (Where deceased lived. If institution: Residence before admission) a. STATE <u>Mo.</u> b. COUNTY <u>Clark</u> c. CITY OR TOWN <u>Kahaka</u> Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>Dunne Rest Home</u> Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>		d. STREET ADDRESS (If outside, give location) Reside on Farm Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	

<b>3. NAME OF DECEASED</b> (Type or print) First <u>Mary</u> Middle <u>Amelia</u> Last <u>Sherwood</u>			<b>4. DATE OF DEATH</b> Month <u>Nov.</u> Day <u>26</u> Year <u>1960</u>			
5. SEX <u>female</u>	6. COLOR OR RACE <u>White</u>	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <u>7/6/1873</u>	9. AGE (last birthday) <u>87</u>	IF UNDER 1 YEAR Months _____ Days _____ Hours _____	IF UNDER 24 HR Min. _____
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housekeeping</u>		10b. KIND OF BUSINESS OR INDUSTRY _____		11. BIRTHPLACE (City and state or country) <u>Missouri</u>		12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>
13a. FATHER'S NAME <u>Charles Devance</u>		13b. MOTHER'S MAIDEN NAME <u>Mary Mauck</u>		14. NAME OF HUSBAND OR WIFE <u>Clarence Sherwood</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>None</u>		17. INFORMANT Address <u>Cecil Calvert - Reeve Mo.</u>		

<b>18. CAUSE OF DEATH</b> (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>medullary failure</u> DUE TO (b) <u>Cerebrovascular thrombosis</u> DUE TO (c) <u>Arteriosclerosis</u>		INTERVAL BETWEEN ONSET AND DEATH <u>minutes</u>  <u>days</u>  <u>Unknown</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>Arteriosclerosis</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 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 checked="" 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>6-26-59</u> to <u>11-26-60</u> and last saw <sup>her</sup> him alive on <u>11-26-60</u> Death occurred at <u>9:15</u> <u>12</u> m on the date stated above, and to the best of my knowledge, from the causes stated.				

22a. SIGNATURE (Degree or title) <u>R. G. Wilkins MD</u>		22b. ADDRESS <u>Kahaka Mo</u>		22c. DATE SIGNED <u>12-26-60</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE <u>Nov. 28-1960</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Peasville Cemetery</u>	
24. FUNERAL DIRECTOR <u>Chas. S. Tuttle - Kahaka Mo</u>		25. DATE REC'D. BY LOCAL REG. <u>12-3-60</u>		26. REGISTRAR'S SIGNATURE <u>J. P. ...</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 Chris L. Sutter

Licensed Embalmer No. 2965

P. O. Address \_\_\_\_\_

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.