

# RI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

FILED VS DEC 15 1960

-60-041462

STATE FILE NUMBER

Registration District No. 88 Primary Registration District No. 5326 Registrar's No. 34

INDEXED

|   |  |   |  |  |   |  |   |  |                                  |  |  |  |  |
|---|--|---|--|--|---|--|---|--|----------------------------------|--|--|--|--|
| 1. PLACE OF DEATH<br>a. COUNTY <u>Crawford</u>  |  |   |  | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <u>Mo.</u> b. COUNTY <u>Crawford</u>                   |   |  |   |  |                                  |  |  |  |  |
| b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Meramec</u>  |  | Length of stay in 1b <u>7 days</u>  |  | c. CITY OR TOWN <u>Crawford Meramec</u>  |   | Inside Limits<br>Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> |   |  |                                  |  |  |  |  |
| c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>W.D. [unclear]</u>   |  |   | Inside Limits<br>Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> |  | d. STREET ADDRESS (If outside, give location) |  | Reside on Farm<br>Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> |  |                                  |  |  |  |  |
| 3. NAME OF DECEASED (Type or print)<br>First <u>JAMES</u> Middle <u>Alfred</u> Last <u>Ettor</u>  |  |   |  | 4. DATE OF DEATH<br>Month <u>Dec.</u> Day <u>10</u> Year <u>1960</u>   |   |  |   |  |                                  |  |  |  |  |
| 5. SEX <u>Male</u>  |  | 6. COLOR OR RACE <u>White</u>   |  | 7. Married <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/> |   | 8. DATE OF BIRTH <u>3-29-1936</u>  |   | 9. AGE (last birthday)<br>Months <u>24</u> Days <u>11</u>  |                                  | IF UNDER 1 YEAR<br>Hours <u>11</u> Min.      |  | IF UNDER 24 HR                                     |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><u>Amvaler</u>   |  |   |  | 10b. KIND OF BUSINESS OR INDUSTRY  |   |  |   | 11. BIRTHPLACE (City and state or country)<br><u>Hardin, Illinois</u>  |                                  | 12. CITIZEN OF WHAT COUNTRY<br><u>U.S.A.</u> |  |  |  |
| 13a. FATHER'S NAME<br><u>Willis D. Ettor</u>  |  |   |  | 13b. MOTHER'S MARDEN NAME<br><u>Sadie Pauline Carns</u>  |   |  |   | 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)<br><u>no</u>   |  |   |  | 16. SOCIAL SECURITY NO.<br><u>None</u>   |   | 17. INFORMANT<br><u>Willis D. Ettor, No 2, Cuba Mo</u>                               |   |  |                                  |  |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Muscular Dystrophy</u><br>DUE TO (b) _____<br>DUE TO (c) _____<br>Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. |  |   |  |  |   |  |   |  |                                  |  |  | INTERVAL BETWEEN ONSET AND DEATH<br><u>24 yrs.</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.<br><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<br>Hour _____ Month, Day, Year _____<br>a.m. _____ p.m. _____   |  |   |  |  |   |  |   |  |                                  |  |  |  |  |
| 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>12/9/60</u> to <u>12/10/60</u> and last saw <u>him</u> alive on <u>12/10/60</u><br>Death occurred at <u>12:05 a</u> m on the date stated above, and to the best of my knowledge, from the causes stated.  |  |   |  |  |   |  |   |  |                                  |  |  |  |  |
| 22a. SIGNATURE <u>Frank A. Elders, M.D.</u> (Degree or title)   |  |   |  |  |   | 22b. ADDRESS <u>Cuba Mo.</u>   |   |  | 22c. DATE SIGNED <u>12/10/60</u> |  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><u>Removal</u>   |  | 23b. DATE <u>12-10-1960</u>   |  | 23c. NAME OF CEMETERY OR CREMATORY<br><u>Hardin Cemetery</u>   |   | 23d. LOCATION (City, town, or county)<br><u>Hardin Illinois</u>                      |   | (State)  |                                  |  |  |  |  |
| 24. FUNERAL DIRECTOR<br><u>Paul J. Smith, Cuba, Mo</u>  |  |   |  | 25. DATE RECD. BY LOCAL REG.<br><u>12/12/60</u>  |   | 26. REGISTRAR'S SIGNATURE<br><u>Mrs. Hazel Lickins</u>                               |   |  |                                  |  |  |  |  |

(Licensed Embalmer's Statement on Reverse Side)

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

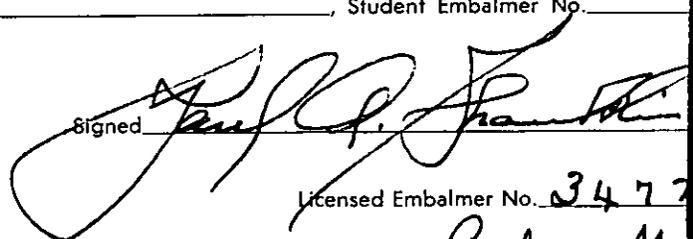
VS DEC 29 1960

**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



Licensed Embalmer No. 3477

P. O. Address Cuba, Mo

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