

JRI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-60-041495

FILED VS NOV 21 1960

Registration District No. 100 Primary Registration District No. 3018 Registrar's No. 94 STATE FILE NUMBER

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1. PLACE OF DEATH a. COUNTY <b>Dent</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Missouri</b> b. COUNTY <b>Dent</b>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>Salem</b>		Length of stay in 1b <b>72 yrs</b>	c. CITY OR TOWN <b>Salem</b> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>Hart Clinic</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <b>Hamilton Add</b> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print) First <b>Earl Henry</b> Middle <b>Westing</b> Last			4. DATE OF DEATH Month <b>Nov</b> Day <b>16</b> Year <b>1960</b>	
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5. SEX <b>male</b>	6. COLOR OR RACE <b>white</b>	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <b>12-15-82</b>	9. AGE (last birthday) <b>77</b>	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HR
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>rural mail carrier</b>	10b. KIND OF BUSINESS OR INDUSTRY <b>x</b>	11. BIRTHPLACE (City and state or country) <b>California Mo</b>	12. CITIZEN OF WHAT COUNTRY <b>U S A</b>
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13a. FATHER'S NAME <b>Henry Westing</b>	13b. MOTHER'S MAIDEN NAME <b>Charlotte Westing</b>	14. NAME OF HUSBAND OR WIFE <b>Abbie Dye</b>
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No x</b>	16. SOCIAL SECURITY NO. <b>x</b>	17. INFORMANT Address <b>Henry Westing Kansas City Mo</b>
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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) <b>Cerebral hemorrhage</b>		INTERVAL BETWEEN ONSET AND DEATH <b>5 days</b>
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)		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.)
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20c. TIME OF INJURY Hour <input type="checkbox"/> a.m. <input type="checkbox"/> p.m.	Month, Day, Year
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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
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21. I attended the deceased from 11/11/60 to 11/16/60 and last saw <sup>her</sup>him alive on 11/16/60  
Death occurred at 5:45 P. m on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) <b>M. M. Hart M.D.</b>	22b. ADDRESS <b>Salem Mo.</b>	22c. DATE SIGNED <b>11/19/60</b>
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23a. BURIAL, CREMATION, REMOVAL (Specify) <b>burial</b>	23b. DATE <b>11-19-60</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Cedar Grove Cem</b>	23d. LOCATION (City, town, or county) (State) <b>Salem Mo</b>
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24. FUNERAL DIRECTOR ADDRESS <b>Spencer Funeral Home Inc</b>	25. DATE RECD. BY LOCAL REG. <b>11/19/60</b>	26. REGISTRAR'S SIGNATURE <b>M. M. Hart M.D. by [Signature]</b>
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DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

NOV 30 1960

DEC 2 1960

**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 Carl H. Spitzer

Licensed Embalmer No. 238

P. O. Address Suburban

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.