

# JRI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

## FILED VS DEC 1 2 1960

-60-041499

NDED

Registration District No. 101 Primary Registration District No. \_\_\_\_\_ Registrar's No. 52

STATE FILE NUMBER

1. PLACE OF DEATH a. COUNTY <u>DOUGLAS</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MO.</u> b. COUNTY <u>DOUGLAS</u>			
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>CASS Twnshp.</u>		Length of stay in 1b <u>11 YRS.</u>		c. CITY OR TOWN <u>NORWOOD</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>Home</u>		Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>		d. STREET ADDRESS (If outside, give location) <u>Rt 2</u>		Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>CORA</u> Middle <u>MAY</u> Last <u>CASADAY</u>				4. DATE OF DEATH Month <u>NOV.</u> Day <u>29</u> Year <u>1960</u>			
5. SEX <u>F.</u>	6. COLOR OR RACE <u>W</u>	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <u>MAR. 9 1877</u>	9. AGE (last birthday) <u>83</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>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY _____		11. BIRTHPLACE (City and state or country) <u>Ohio</u>		12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>	
13a. FATHER'S NAME <u>Alonzo Redkey</u>		13b. MOTHER'S MAIDEN NAME <u>SARAH Elizabeth Lindsay</u>		14. NAME OF HUSBAND OR WIFE <u>John R.</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 <u>K.D. CASADAY</u> Address <u>Rt 2 Norwood Mo</u>			
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>Haemorrhage. Cerebral</u> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <u>Hypertension, Cerebrovascular</u> DUE TO (c) <u>Cerebral Thrombosis</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						INTERVAL BETWEEN ONSET AND DEATH <u>11-23-60</u>	
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.) <u>See above</u>		20f. CITY, TOWN, OR LOCATION <u>See above</u>		COUNTY _____ STATE _____	
21. I attended the deceased from <u>May 1950</u> to <u>Nov 29, 1950</u> and last saw her alive on <u>Nov 23 1960</u> Death occurred at <u>11:50A</u> on the date stated above, and to the best of my knowledge, from the causes stated.							
22a. SIGNATURE <u>[Signature]</u> (Degree or title) <u>MD</u>				22b. ADDRESS <u>Mountain Grove Mo</u>		22c. DATE SIGNED <u>12-3-60</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>REMOVAL</u>		23b. DATE <u>Dec. 2, 1960</u>		23c. NAME OF CEMETERY OR CREMATORY <u>WALNUT GROVE</u>		23d. LOCATION (City, town, or county) (State) <u>Andrew County Mo</u>	
24. FUNERAL DIRECTOR <u>Rox &amp; Miller</u>		ADDRESS <u>Manassas Mo</u>		25. DATE RECD. BY LOCAL REG. <u>12-9-60</u>		26. REGISTRAR'S SIGNATURE <u>Uestel Bushman</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

*Max L Miller*

Licensed Embalmer No. *4720*

P. O. Address *Manofield*

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