

JURY DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-60-041590

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Registration District No. 4196 Registrar's No. 93

STATE FILE NUMBER

1. PLACE OF DEATH a. COUNTY <b>Gentry</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Missouri</b> b. COUNTY <b>North</b>			
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>Albany</b>		Length of stay in 1b <b>4 days</b>		c. CITY OR TOWN <b>Grant City</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>Gentry Co. Memorial Hosp.</b>				Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location) Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Nettie</b> Middle <b>Louise</b> Last <b>Hiatt</b>				4. DATE OF DEATH Month <b>October</b> Day <b>26,</b> Year <b>1960</b>			
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>		8. DATE OF BIRTH <b>9-27-75</b>	9. AGE (last birthday) <b>85</b>	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) <b>Housekeeper</b>			10b. KIND OF BUSINESS OR INDUSTRY <b>Own home</b>	11. BIRTHPLACE (City and state or country) <b>Ford County, Illinois</b>		12. CITIZEN OF WHAT COUNTRY <b>U. S.</b>	
13a. FATHER'S NAME <b>Nelson Tilden Lewis</b>			13b. MOTHER'S MAIDEN NAME <b>Katherine McQuade</b>		14. NAME OF HUSBAND OR WIFE <b>Linder Hiatt</b>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>			16. SOCIAL SECURITY NO. <b>None</b>	17. INFORMANT Address <b>Mrs. Ruth Kier - Grant City, Missouri</b>			
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>TOXEMIA</b>						INTERVAL BETWEEN ONSET AND DEATH <b>3 WEEKS</b>	
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <b>UREMIA</b>						<b>3-6 WEEKS</b>	
DUE TO (c) <b>ARTERIO-SCLEROTIC NEPHROSIS</b>						<b>YEARS</b>	
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 checked="" 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 Month, Day, Year a.m. p.m.							
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 <b>1955</b> to <b>Oct. 25, 1960</b> and last saw her <sup>him</sup> alive on <b>Oct. 25, 1960</b> Death occurred at <b>6:00 A.M.</b> on the date stated above, and to the best of my knowledge, from the causes stated.							
22a. SIGNATURE (Degree or title) <b>Richard J. Smith D.O.</b>				22b. ADDRESS <b>Grant City, Mo.</b>		22c. DATE SIGNED <b>10-26-60</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>burial</b>	23b. DATE <b>10-28-1960</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Grant City Cemetery</b>		23d. LOCATION (City, town, or county) (State) <b>Grant City, Missouri</b>			
24. FUNERAL DIRECTOR ADDRESS <b>Bill Duffer - Grant City, Mo.</b>			25. DATE RECD. BY LOCAL REG. <b>11-28-60</b>		26. REGISTRAR'S SIGNATURE <b>Mrs. L. W. Bare</b>		

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 me  
or by \_\_\_\_\_, Student Embalmer No. \_\_\_\_\_  
working under my personal supervision.

Student \_\_\_\_\_  
Signature of Student Embalmer

Signed Bill A. Dunfee

Licensed Embalmer No. 4908

P. O. Address. Grant City

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