

JRI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-60-041739

FILED VS DEC 5 1960

132

197

STATE FILE NUMBER

INDEXED

Registration District No. _____ Primary Registration District No. _____ Registrar's No. _____

1. PLACE OF DEATH a. COUNTY <i>Grundy</i>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <i>mo</i> b. COUNTY <i>Grundy</i>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <i>Leahy Sup.</i>	Length of stay in 1b <i>Life</i>	c. CITY OR TOWN <i>Salt</i>	Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <i>one half mile W. Salt</i>		d. STREET ADDRESS (If outside, give location) <i>Leahy Sup.</i>	Reside on Farm Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>

3. NAME OF DECEASED (Type or print) First <i>MAUD</i> Middle <i>NINA</i> Last <i>MAGEEHOE</i>			4. DATE OF DEATH Month <i>11</i> Day <i>28</i> Year <i>1960</i>			
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5. SEX <i>F.</i>	6. COLOR OR RACE <i>W.</i>	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <i>5-23-1875</i>	9. AGE (last birthday) <i>85</i>	IF UNDER 1 YEAR Months _____ Days _____	IF UNDER 24 HR Hours _____ Min. _____
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY <i>Housewife</i>	11. BIRTHPLACE (City and state or country) <i>Sumner, Mo</i>	12. CITIZEN OF WHAT COUNTRY <i>USA</i>
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13a. FATHER'S NAME <i>Carroll McCall</i>	13b. MOTHER'S MAIDEN NAME <i>Ann Heune</i>	14. NAME OF HUSBAND OR WIFE <i>E. N. Magee</i>
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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)	16. SOCIAL SECURITY NO. <input checked="" type="checkbox"/>	17. INFORMANT <i>Kenneth Magee</i> Address <i>Salt mo</i>
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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) <i>Chronic Hypertension, terminal Hypertensive Hemorrhage</i>		INTERVAL BETWEEN ONSET AND DEATH <i>3 days</i>	
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) <i>generalized arteriosclerotic disease</i>		<i>10-15 years</i>
	DUE TO (c) <i>Epilepsy</i>		<i>25 years</i>

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 _____ a.m. _____ 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 *July 1950* to *Nov 1960* and last saw her alive on *November 26-1960*
Death occurred at *4:20 a.m.* on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE <i>A. W. [illegible]</i> (Degree or title)	22b. ADDRESS <i>Salt Mo</i>	22c. DATE SIGNED <i>11-28-60</i>
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23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>	23b. DATE <i>11-30-1960</i>	23c. NAME OF CEMETERY OR CREMATORY <i>Salt Cemetery</i>	23d. LOCATION (City, town, or county) (State) <i>Salt mo</i>
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24. FUNERAL DIRECTOR <i>Rayne Funeral Home</i> ADDRESS <i>Salt mo</i>	25. DATE RECD. BY LOCAL REG. <i>11-30-60</i>	26. REGISTRAR'S SIGNATURE <i>J. [illegible]</i>
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(Licensed Embalmer's Statement on Reverse Side)

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

FEB 8 1961

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 DR Payne Jr

Licensed Embalmer No. 3400

P. O. Address Salt

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.