

MARI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

FILED VS DEC 5 1960

-60-041772
STATE FILE NUMBER

Registration District No. 137 Primary Registration District No. 4208 Registrar's No. 277

1. PLACE OF DEATH a. COUNTY <u>Henry</u> b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Windsor,</u> Length of stay in 1b <u>2 months</u> c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>Windsor Community Hospital</u> Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Henry</u> c. CITY OR TOWN <u>Windsor,</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> d. STREET ADDRESS (If outside, give location) <u>807 S. Main St.</u> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
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3. NAME OF DECEASED (Type or print) First <u>EDWARD</u> Middle <u>H.</u> Last <u>SAXTON</u>	4. DATE OF DEATH Month <u>November</u> Day <u>19th.</u> Year <u>1960</u>
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5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <u>9-14-1888</u>	9. AGE (last birthday) <u>72</u>	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) <u>Retired Church Custodian</u>	10b. KIND OF BUSINESS OR INDUSTRY <u>Custodian,</u>	11. BIRTHPLACE (City and state or country) <u>Leeton, Johnson Co., Mo.</u>	12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>
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13a. FATHER'S NAME <u>David H. Saxton,</u>	13b. MOTHER'S MAIDEN NAME <u>McMillen,</u>	14. NAME OF HUSBAND OR WIFE <u>Eva Saxton,</u>
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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) <u>no</u>	16. SOCIAL SECURITY NO. <u>494-20-7706</u>	17. INFORMANT Address <u>Mrs. Eva Saxton, Windsor, Missouri</u>
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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) <u>Cerebral hemorrhage</u> DUE TO (b) <u>Hypertension</u> DUE TO (c) _____ Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	INTERVAL BETWEEN ONSET AND DEATH <u>72 hrs</u> <u>? years</u>
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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 II-19-1960 to II-19-1960 and last saw ^{him} alive on II-19-1960
 Death occurred at 5:00 P.M. on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE <u>Demard Brock</u> (Degree or title) <u>M.D.</u>	22b. ADDRESS <u>Windsor, Missouri.</u>	22c. DATE SIGNED <u>II-19-60</u>
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23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE <u>II-21-1960</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Mineral Creek Cemetery,</u>	23d. LOCATION (City, town, or county) (State) <u>Leeton, Missouri</u>
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24. FUNERAL DIRECTOR ADDRESS <u>The Brauningers, Warrensburg, Missouri</u>	25. DATE RECD. BY LOCAL REG. <u>Nov. 28, 1960</u>	26. REGISTRAR'S SIGNATURE <u>Mildred Bigum</u>
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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 J.P.A. Branninger

Licensed Embalmer No. 3377

P. O. Address W. Amosburg

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.