

FEDERAL DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

=60-041799

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Registration District No. 141 Primary Registration District No. 3025 Registrar's No. 173

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>West Plains</u>		Length of stay in 1b <u>Mo's</u>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>W. Hill Str.</u>		d. STREET ADDRESS (If outside, give location) <u>W. Hill Str.</u>	
3. NAME OF DECEASED (Type or print) <u>Charley Long</u>		4. DATE OF DEATH <u>11/22-60</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. Married <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <u>7-1-71</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>unemployed</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>retirement</u>	12. CITIZEN OF WHAT COUNTRY <u>USA</u>
13a. FATHER'S NAME <u>unint</u>		14. NAME OF HUSBAND OR WIFE <u>unint</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>unint</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Vascular Thrombosis</u>			INTERVAL BETWEEN ONSET AND DEATH <u>6 hrs</u>
DUE TO (b) <u>Arteriosclerosis</u>			<u>10 yrs</u>
DUE TO (c) <u>Vascular degeneration due to senility</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>Cardiac Decompensation</u>			PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> N. <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			
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 <u>4:30 A.</u> to <u>11-21-60</u> and last saw him alive on <u>11-21-60</u> Death occurred at <u>4:30 A.</u> m on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree or title) <u>Murray T. Pritchard, M.D.</u>		22b. ADDRESS <u>913 W. Main West Plains, Mo</u>	22c. DATE SIGNED <u>12-4-60</u>
23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE <u>11/25-60</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Oak Lawn</u>	23d. LOCATION (City, town, or county) (State) <u>West Plains Mo</u>
24. FUNERAL DIRECTOR <u>Charles Matthews</u>		25. DATE RECD. BY LOCAL REG. <u>12-7-60</u>	26. REGISTRAR'S SIGNATURE <u>Beatrice Cook</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 A. S. Roberts

Licensed Embalmer No. 3437

P. O. Address West

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.