

JRI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-60-042445

ED VS NOV 30 1960

157 Primary Registration District No. 3028 Registrar's No. 238

STATE FILE NUMBER

NDED

1. PLACE OF DEATH a. COUNTY Jasper				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY Jasper									
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Carthage		Length of stay in lb 60 yrs.		c. CITY OR TOWN Carthage		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>							
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION McCune Brooks Hospital			Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location) 400 East 3rd St		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>						
3. NAME OF DECEASED (Type or print) First Middle Last NELLIE WRIGHT KEITH				4. DATE OF DEATH Month 11 Day 23 Year 1960									
5. SEX female		6. COLOR OR RACE white		7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>		8. DATE OF BIRTH 11-23-1895		9. AGE (last birthday) 65		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HR	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife			10b. KIND OF BUSINESS OR INDUSTRY at home			11. BIRTHPLACE (City and state or country) Carthage, Missouri			12. CITIZEN OF WHAT COUNTRY U S A				
13a. FATHER'S NAME Charles A. Parker				13b. MOTHER'S MAIDEN NAME Emily J. Cagle				14. NAME OF HUSBAND OR WIFE Harry E. Keith					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no				16. SOCIAL SECURITY NO. none		17. INFORMANT Address Harry E. Keith 400 E. 3rd., Carthage, Mo.							
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>arteriosclerotic 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>2 days</u> <u>8 yrs</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"/> 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 _____ a.m. _____ p.m.		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>5-27-52</u> to <u>11-23-1960</u> and last saw her/him alive on <u>11-23-1960</u> Death occurred at <u>11:03 A.M.</u> on the date stated above, and to the best of my knowledge, from the causes stated.													
22a. SIGNATURE (Degree or title) <u>M. Carter Whitton</u> M.D.						22b. ADDRESS Carthage, Mo.			22c. DATE SIGNED 11-26-60				
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 11-28-60		23c. NAME OF CEMETERY OR CREMATORY Park Cemetery			23d. LOCATION (City, town, or county) Carthage		STATE Missouri				
24. FUNERAL DIRECTOR ADDRESS KNELL MORTUARY 308 W. Chestnut, Carthage				25. DATE RECD. BY LOCAL REG. 11-26-60		26. REGISTRAR'S SIGNATURE <u>My Clinton</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 Frank W. Kneel

Licensed Embalmer No. 4440

P. O. Address Carthage, Mo.

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.