

RI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

FILED VS NOV 22 1960

-60-042620

Registration District No. 170 Primary Registration District No. _____ Registrar's No. 165

STATE FILE NUMBER

DED

1. PLACE OF DEATH a. COUNTY <u>Laclede</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Mo.</u> b. COUNTY <u>Laclede</u>									
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Lebanon T.S.</u>		Length of stay in lb <u>20 yrs.</u>		c. CITY OR TOWN <u>Phillipsburg</u>		Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>							
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>6mi. S.W. Lebanon, Mo.</u>			Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>		d. STREET ADDRESS (If outside, give location) <u>Rural Rt. 1</u>		Reside on Farm Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>						
3. NAME OF DECEASED (Type or print) First <u>Nelle</u> Middle <u>Brown</u> Last <u>Jeffery</u>				4. DATE OF DEATH Month <u>Nov.</u> Day <u>11</u> Year <u>1960</u>									
5. SEX <u>female</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>1-29-10</u>		9. AGE (last birthday) <u>50</u>		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) <u>housewife</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>housewife</u>				11. BIRTHPLACE (City and state or country) <u>KENTUCKY</u>		12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>			
13a. FATHER'S NAME <u>Joe T. Edwards</u>				13b. MOTHER'S MAIDEN NAME <u>Leola B. Locker</u>				14. NAME OF HUSBAND OR WIFE <u>James Jeffery</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>493-03-0324</u>		17. INFORMANT <u>James Jeffery</u> Address <u>Rt. 1 Phillipsburg, Mo.</u>							
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>Cancer left Breast</u>										INTERVAL BETWEEN ONSET AND DEATH <u>April 1959</u>			
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <u>Generalized metastasis</u>													
DUE TO (c) <u>Abdominal bone + lymphatics 8 mo. 8 mo</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"/> 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 _____ 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>30 March 1960</u> to <u>11 Nov. 1960</u> and last saw her/him alive on <u>9 Nov. 1960</u> Death occurred at <u>1:20 A.</u> m on the date stated above, and to the best of my knowledge, from the causes stated.													
22a. SIGNATURE <u>Paul A. Justice MD</u> (Degree or title)						22b. ADDRESS <u>Knight Bldg. Lebanon, Mo.</u>			22c. DATE SIGNED <u>14 Nov. 1960</u>				
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>burial</u>		23b. DATE <u>11-13-60</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Mt. Rose Memorial Park</u>			23d. LOCATION (City, town, or county) (State) <u>Lebanon, Laclede, Mo.</u>						
24. FUNERAL DIRECTOR <u>J. Shadel</u> ADDRESS <u>Lebanon, Mo.</u>				25. DATE RECD. BY LOCAL REG. <u>11-15-1960</u>		26. REGISTRAR'S SIGNATURE <u>Hella L. Hays</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. 4739
working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed Gene P. Hunter

Licensed Embalmer No. 4739

P. O. Address Spfld, Ill

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