

DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-60-042717

ED VS DEC 12 1960

Registration District No. 385 Primary Registration District No. 3039 Registrar's No. 161

STATE FILE NUMBER

1. PLACE OF DEATH a. COUNTY <u>Linn</u> b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Marceline</u> Length of stay in 1b _____ c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>St. Francis Hosp.</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MO</u> b. COUNTY <u>Linn</u> c. CITY OR TOWN <u>Marceline</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> d. STREET ADDRESS (If outside, give location) <u>216 W. Gracia</u> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Harley</u> Middle <u>E.</u> Last <u>Trader</u>			4. DATE OF DEATH Month <u>11</u> Day <u>30</u> Year <u>1960</u>				
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</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>12-13-1876</u>	9. AGE (last birthday) <u>83</u>	IF UNDER 1 YEAR Months <u>11</u> Days <u>17</u>	IF UNDER 24 HR Hours _____ Min. _____	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Pres. Bank</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Retired</u>		11. BIRTHPLACE (City and state or country) <u>Linn, MO</u>		12. CITIZEN OF WHAT COUNTRY <u>U.S.A</u>	
13a. FATHER'S NAME <u>Samuel</u>			13b. MOTHER'S MAIDEN NAME <u>Anna Kaziah</u>		14. NAME OF HUSBAND OR WIFE <u>Agnes</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.		17. INFORMANT Address <u>Mrs. H.E. Trader Marceline 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>Arteriosclerotic Cardio-vascular disease</u> DUE TO (b) <u>Arteriosclerosis, generalized</u> DUE TO (c) _____ Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.						INTERVAL BETWEEN ONSET AND DEATH _____	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>Senile psychosis; Senia; Cerebrovascular Accident</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 _____ 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 _____, to _____, and last saw her/him alive on _____. Death occurred at _____ m on the date stated above, and to the best of my knowledge, from the causes stated.							
22a. SIGNATURE (Degree or title) <u>James M. Laughlin</u>				22b. ADDRESS <u>Marceline Linn MO</u>		22c. DATE SIGNED <u>12-2-60</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>B</u>		23b. DATE <u>12/2/1960</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Mt. Olive</u>		23d. LOCATION (City, town, or county) (State) <u>Marceline MO.</u>		
24. FUNERAL DIRECTOR ADDRESS <u>James M. Laughlin Marceline MO</u>			25. DATE RECD. BY LOCAL REG. <u>12-2-1960</u>		26. REGISTRAR'S SIGNATURE <u>Broonie Owens</u>		

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

DEC 20 1960

GEORGE GARY M.D.

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 Guad I. Wa

Licensed Embalmer No. 417

P. O. Address Brown

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.