

FEDERAL DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-60-042725

LED VS DEC 14 1960

Registration District No. 182 Primary Registration District No. 5686 Registrar's No. 27 STATE FILE NUMBER

1. PLACE OF DEATH a. COUNTY <u>LINN</u>				2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE <u>Mo.</u> b. COUNTY <u>LINN</u>						
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>LOCUST CREEK</u>		Length of stay in 1b <u>20 YRS</u>		c. CITY OR TOWN <u>LINNEUS</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>1 MILE W. OF LINNEUS</u>			Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>		d. STREET ADDRESS (If outside, give location) <u>1 MILE WEST</u>		Reside on Farm Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>RACHEL</u> Middle <u>M. ROBINSON</u> Last				4. DATE OF DEATH Month <u>12</u> Day <u>8</u> Year <u>60</u>						
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>		8. DATE OF BIRTH <u>12-14-82</u>	9. AGE (last birthday) <u>77</u>	IF UNDER 1 YEAR Months	IF UNDER 24 HR Days	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		11. BIRTHPLACE (City and state or country) <u>SHELBY, Mo.</u>		12. CITIZEN OF WHAT COUNTRY <u>USA</u>			
13a. FATHER'S NAME <u>PETER BAILEY</u>			13b. MOTHER'S MAIDEN NAME <u>ELLA WALKER</u>			14. NAME OF HUSBAND OR WIFE <u>MELVIN</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>NONE</u>		17. INFORMANT <u>JIMMIE ROBINSON, LINNEUS, Mo.</u>				Address	
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>3d DEGREE BURNS AND SHOCK</u>								INTERVAL BETWEEN ONSET AND DEATH <u>IMMED</u>		
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.		DUE TO (b) <u>3/4 OF BODY AREA BURNED</u>								
		DUE TO (c)								
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 checked="" type="checkbox"/> No <input type="checkbox"/> Unknown				
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20a. ACCIDENT <input checked="" 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.) <u>CLOTHING ACCIDENTLY CAUGHT ON FIRE</u>								
20c. TIME OF INJURY Hour <u>7:00</u> a.m. p.m.	Month, Day, Year			20d. INJURY OCCURRED WHILE AT WORK <input checked="" 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.) <u>Home</u>		20f. CITY, TOWN, OR LOCATION <u>LINNEUS</u>		COUNTY <u>LINN</u>		STATE <u>Mo.</u>				
21. I attended the deceased from _____ to _____ and last saw her/him alive on _____ Death occurred at <u>7:00</u> p. m on the date stated above, and to the best of my knowledge, from the causes stated.										
22a. SIGNATURE (Degree or title) <u>M.R. Wright</u> <u>Coroner</u>				22b. ADDRESS <u>Meadville, Mo.</u>				22c. DATE SIGNED <u>12-9-60</u>		
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE <u>12-10-60</u>	23c. NAME OF CEMETERY OR CREMATORY <u>GROVE HILL CEM</u>		23d. LOCATION (City, town, or county) <u>LINN COUNTY</u>			STATE <u>Mo.</u>		
24. FUNERAL DIRECTOR <u>WRIGHT'S, LINNEUS, Mo.</u>				ADDRESS		DATE RECD. BY LOCAL REG. <u>Dec 10 - 1960</u>		26. REGISTRAR'S SIGNATURE <u>Mrs. Birdie Kelley</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 H. R. Knight

Licensed Embalmer No. 465

P. O. Address Meadville,

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