

RI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-60-042892

VS NOV 29 1960

Registration District No. 236 Primary Registration District No. 4352 Registrar's No. 76

STATE FILE NUMBER

| | | | | | | | | |
|---|--|---|--|--|---|--|--|---|
| 1. PLACE OF DEATH a. COUNTY <u>Morgan</u> | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Mo.</u> b. COUNTY <u>Morgan</u> | | | | |
| b. CITY (If outside corporate limits, give TOWNSHIP only) <u>Versailles</u> | | | Length of stay in 1b <u>5 Years</u> | | c. CITY OR TOWN <u>Versailles</u> | | Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> | |
| c. FULL NAME OF (if NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>Missouri Ave.</u> | | | | Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> | | d. STREET ADDRESS (If outside, give location) <u>Missouri Ave.</u> | | Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> |
| 3. NAME OF DECEASED (Type or print) First <u>Bertha</u> Middle <u>Mae</u> Last <u>Colton</u> | | | | | | 4. DATE OF DEATH Month <u>November</u> Day <u>21</u> Year <u>1960</u> | | |
| 5. SEX <u>Female</u> | 6. COLOR OR RACE <u>Cau.</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>12-5-1890</u> | 9. AGE (last birthday) <u>69</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 | | 11. BIRTHPLACE (City and state or country) <u>Camden County, Mo.</u> | | 12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u> | |
| 13a. FATHER'S NAME <u>John McCasland</u> | | | 13b. MOTHER'S MAIDEN NAME <u>Rosie Cartwell</u> | | | 14. NAME OF HUSBAND OR WIFE <u>Thomas C. Colton</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>500-10-5789</u> | | 17. INFORMANT <u>Oliver Colton, Kansas City, 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>Wrenia</u> DUE TO (b) <u>Essential 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>1 week</u> <u>15 years</u> | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>Fracture Hips - 2 yrs</u> | | | | | | 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>1945</u> to <u>Nov 21, 1960</u> and last saw her alive on <u>11/19/60</u> Death occurred at <u>9:30 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>J L Washburn M.D.</u> | | | | 22b. ADDRESS <u>Versailles, Mo</u> | | 22c. DATE SIGNED <u>11/27/60</u> | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | | 23b. DATE <u>23 Nov. 60</u> | 23c. NAME OF CEMETERY OR CREMATORY <u>Versailles Cemetery</u> | | 23d. LOCATION (City, town, or county) <u>Versailles, Mo.</u> | | | |
| 24. FUNERAL DIRECTOR <u>Hidwell Funeral Home Versailles, Mo.</u> | | | | 25. DATE RECD. BY LOCAL REG. <u>11/25/60</u> | | 26. REGISTRAR'S SIGNATURE <u>J L Washburn</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 Raymond C. Barber

Licensed Embalmer No. 4626

P. O. Address Norwalk

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.