

**JRI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH**

**=60-044921**

**FILED VS NOV 23 1960 360**

Registration District No. \_\_\_\_\_ Primary Registration District No. **6225** Registrar's No. **230**

STATE FILE NUMBER

INDEXED

<b>1. PLACE OF DEATH</b> a. COUNTY <u>Vernon</u> b. CITY (if outside corporate limits, give TOWNSHIP only) OR TOWN <u>Hustington 1st</u> Length of stay in 1b <u>2 yr</u> c. FULL NAME OF (if NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>St Hosp # 3</u> Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>				<b>2. USUAL RESIDENCE</b> (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Vernon</u> c. CITY OR TOWN <u>Nevada</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> d. STREET ADDRESS (if outside, give location) <u>North Ash Street.</u> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>			
<b>3. NAME OF DECEASED</b> (Type or print) First <u>Maud</u> Middle <u>777</u> Last <u>Blair</u>			<b>4. DATE OF DEATH</b> Month <u>11</u> Day <u>5</u> Year <u>1960</u>				
<b>5. SEX</b> <u>F</u>	<b>6. COLOR OR RACE</b> <u>W</u>	<b>7. Married</b> <input type="checkbox"/> <b>Never Married</b> <input type="checkbox"/> <b>Widowed</b> <input checked="" type="checkbox"/> <b>Divorced</b> <input type="checkbox"/>	<b>8. DATE OF BIRTH</b> <u>3-18-84</u>	<b>9. AGE (last birthday)</b> <u>76</u>	<b>IF UNDER 1 YEAR</b> Months _____ Days _____	<b>IF UNDER 24 HR</b> Hours _____ Min. _____	
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>None</u>		<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <u>None</u>		<b>11. BIRTHPLACE</b> (City and state or country) <u>Mo</u>		<b>12. CITIZEN OF WHAT COUNTRY</b> <u>USA</u>	
<b>13a. FATHER'S NAME</b> <u>Burgess Harshone</u>		<b>13b. MOTHER'S MAIDEN NAME</b> <u>Esther Collins</u>		<b>14. NAME OF HUSBAND OR WIFE</b> <u>deceased</u>			
<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) (If yes, give war or dates of service) <u>no</u>		<b>16. SOCIAL SECURITY NO.</b> <u>495 306780</u>		<b>17. INFORMANT</b> <u>Maud record</u> Address _____			
<b>18. CAUSE OF DEATH</b> (Enter only one code per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>cerebral sclerosis</u> DUE TO (b) <u>Diabetes</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>10 yr</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		
<b>19. WAS AUTOPSY PERFORMED?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	<b>20a. ACCIDENT</b> <input type="checkbox"/>	<b>SUICIDE</b> <input type="checkbox"/>	<b>HOMICIDE</b> <input type="checkbox"/>	<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in PART I or PART II of item 18.)			
<b>20c. TIME OF INJURY</b> Hour _____ a.m. _____ p.m. Month, Day, Year _____							
<b>20d. INJURY OCCURRED WHILE AT WORK</b> <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		<b>20e. PLACE OF INJURY</b> (e.g., in or about home, farm, factory, street, office bldg., etc.)		<b>20f. CITY, TOWN, OR LOCATION</b>		<b>COUNTY</b>	<b>STATE</b>
<b>21. I attended the deceased from</b> <u>11-1-59</u> to <u>11-5-60</u> and last saw her/him alive on <u>11-5-60</u> Death occurred at <u>9:10 P</u> m on the date stated above, and to the best of my knowledge, from the causes stated.							
<b>22a. SIGNATURE</b> (Degree or title) <u>F S Martin MD</u>			<b>22b. ADDRESS</b> <u>St Hosp # 3</u>			<b>22c. DATE SIGNED</b> <u>11-5-60</u> (State)	
<b>23a. BURIAL, CREMATION, REMOVAL</b> (Specify) <u>Burial</u>		<b>23b. DATE</b> <u>11/8/60</u>	<b>23c. NAME OF CEMETERY OR CREMATORY</b> <u>Newton Burial Park</u>		<b>23d. LOCATION</b> (City, town, or county) <u>Nevada Missouri</u>		
<b>24. FUNERAL DIRECTOR</b> ADDRESS <u>Eichinger Funeral Home Nevada Missouri</u>			<b>25. DATE RECD. BY LOCAL REG.</b> <u>Nov 15-1960</u>		<b>26. REGISTRAR'S SIGNATURE</b> <u>Anna E Jerry</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

*S Percy F. Milster*

Licensed Embalmer No. 4805

P. O. Address Norwalk

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.