

RI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

NOV 30 1960

-60-044928

STATE FILE NUMBER

Registration District No. 360 Primary Registration District No. 6225 Registrar's No. 236

DED

| | | | | | | | | |
|---|--|---|--|--|--|---|---|---------|
| 1. PLACE OF DEATH | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) | | | | |
| a. COUNTY <u>Vernon</u> | | b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Washington</u> | | Length of stay in 1b <u>6yr, 10mo, 18da</u> | | c. CITY OR TOWN <u>Red Top</u> | | |
| c. FULL NAME OF (IF NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>State Hospital No. 3</u> | | Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> | | d. STREET ADDRESS (If outside, give location) | | Reside on Farm Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> | | |
| 3. NAME OF DECEASED (Type or print) | | | First <u>James</u> Middle <u>Monroe</u> Last <u>Glover</u> | | | 4. DATE OF DEATH | | |
| | | | | | | Month <u>November</u> Day <u>18</u> Year <u>1960</u> | | |
| 5. SEX <u>Male</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>12-16-74</u> | | |
| | | | | | | 9. AGE (last birthday) <u>85</u> | | |
| | | | | | | IF UNDER 1 YEAR IF UNDER 24 HR | | |
| | | | | | | Months Days Hours Min. | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer</u> | | | 10b. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (City and state or country) <u>Missouri</u> | | 12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u> | |
| 13a. FATHER'S NAME <u>Wesley Glover</u> | | | 13b. MOTHER'S MAIDEN NAME <u>Nancy Prater</u> | | | 14. NAME OF HUSBAND OR WIFE <u>Julia M. Glover</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 <u>Records</u> | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: | | | | | | | INTERVAL BETWEEN ONSET AND DEATH | |
| IMMEDIATE CAUSE (a) <u>Broncho-pneumonia</u> | | | | | | | <u>2 weeks</u> | |
| Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <u>Generalized arteriosclerosis</u> | | | | | | | <u>Years</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 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 <u> </u> Month, Day, Year <u> </u> | | | | | | |
| 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>December 31, 1953</u> to <u>November 18, 1960</u> and last saw ^{her} him alive on <u>November 18, 1960</u> | | | | | | | | |
| Death occurred at <u>7:30</u> <u>a.</u> m on the date stated above, and to the best of my knowledge, from the causes stated. | | | | | | | | |
| 22a. SIGNATURE <u>George Ester M.D.</u> (Degree or title) | | | | 22b. ADDRESS <u>State Hospital No. 3 Nevada, Missouri</u> | | | 22c. DATE SIGNED <u>11-18-60</u> | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | | 23b. DATE <u>Nov. 20, 1960</u> | | 23c. NAME OF CEMETERY OR CREMATORY <u>Rock Prairie Cemetery</u> | | 23d. LOCATION (City, town, or county) <u>Pleasant Hope Missouri</u> | | (State) |
| 24. FUNERAL DIRECTOR <u>Paul D. Butler</u> ADDRESS <u>Bolivar, Missouri</u> | | | 25. DATE RECD. BY LOCAL REG. <u>Nov. 26, 1960</u> | | 26. REGISTRAR'S SIGNATURE <u>Anna E. Jerry</u> | | | |

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

NOV 30 1960

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 Paul D Butcher

Licensed Embalmer No. 447

P. O. Address Bolivar

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.