

FRI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-60-044975

FILED 13 NOV 17 1960

Registration District No. 375 Primary Registration District No. 6287 Registrar's No. 20 STATE FILE NUMBER

1. PLACE OF DEATH a. COUNTY <u>Wright</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Mo.</u> b. COUNTY <u>Wright</u>			
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Montgomery</u>		Length of stay in 1b <u>55 years</u>		c. CITY OR TOWN <u>Manes</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>1/4 mi. West of Manes</u>			Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>		d. STREET ADDRESS (If outside, give location) <u>1/4 mi. West</u>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <u>Pinettie</u> Middle <u>E.</u> Last <u>Julian</u>				4. DATE OF DEATH Month <u>11</u> Day <u>6</u> Year <u>1960</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>3-22-1867</u>	
9. AGE (last birthday) <u>93</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 of country) <u>Wright County, Mo.</u>		12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>
13a. FATHER'S NAME <u>John Long</u>			13b. MOTHER'S MAIDEN NAME <u>Lizic Brown</u>			13c. NAME OF HUSBAND OR WIFE <u>Deceased</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 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>Pneumonia (Lobar)</u>							INTERVAL BETWEEN ONSET AND DEATH <u>3 days</u>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <u>Cardiovascular Renal Disease</u>							years
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 _____ s.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>June 1958</u> to <u>Nov 6, 1960</u> and last saw her ^{her} _{last} alive on <u>Nov 5, 1960</u> . Death occurred at <u>4:30 PM - PM</u> on the date stated above, and to the best of my knowledge, from the causes stated.							
22a. SIGNATURE <u>J. E. Worthy, D.D.</u> (Deceased or title)				22b. ADDRESS <u>Hartsville Mo.</u>		22c. DATE SIGNED <u>11-9-60.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE <u>11-9-1960</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Manes Cemetery</u>		23d. LOCATION (City, town, or county) (State) <u>Manes Mo.</u>	
24. FUNERAL DIRECTOR <u>Charles Althouse Hartsville, Mo.</u> ADDRESS			25. DATE RECD. BY LOCAL REG. <u>11-14-1960</u>		26. REGISTRAR'S SIGNATURE <u>Bonnie J. Jones</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 Max J Miller

Licensed Embalmer No. 4720

P. O. Address Manofield

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.