

R DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-60-045011

7 1960

Registration District No. 002 Primary Registration District No. 5019 Registrar's No. 76

STATE FILE NUMBER

1. PLACE OF DEATH a. COUNTY <u>ANDREW</u>			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MISSOURI</u> COUNTY <u>ANDREW</u>		
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>ROCHESTER TOWNSHIP</u>		Length of stay in 1b <u>3 months</u>	c. CITY OR TOWN <u>RFD # 1, Rea</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>SHADY LAWN</u>		Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <u>1 mile northwest</u>		Reside on Farm Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <u>MARY</u> Middle <u>E.</u> Last <u>ORTON</u>			4. DATE OF DEATH Month <u>December</u> Day <u>16</u> Year <u>1960</u>		
5. SEX <u>female</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>8-10-72</u>	9. AGE (last birthday) <u>88</u>	IF UNDER 1 YEAR Months 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 <u>at home</u>	11. BIRTHPLACE (City and state or country) <u>Gentry County, Mo.</u>		12. CITIZEN OF WHAT COUNTRY <u>U S A</u>
13a. FATHER'S NAME <u>Newton Malson</u>		13b. MOTHER'S MAIDEN NAME <u>Sarah Wood</u>		14. NAME OF HUSBAND OR WIFE <u>C. W. Orton</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>488-22-6351</u>		17. INFORMANT Address <u>C. W. Orton, RFD # 1, Rea, 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>Hypostatic Pneumonia</u> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <u>Fractured Femur</u> DUE TO (c) <u>Fall to Floor.</u>					INTERVAL BETWEEN ONSET AND DEATH <u>45 days.</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	
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>Hour</u> 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>Nov. 7, 1960</u> to <u>Dec. 16, 1960</u> and last saw her alive on <u>Nov. 17, 1960</u> Death occurred at <u>3:00 AM</u> on the date stated above, and to the best of my knowledge, from the causes stated.					
22a. SIGNATURE (Degree or title) <u>W.B. Maxwell, D.O.</u>			22b. ADDRESS <u>307 W. Main, Savannah, Mo.</u>		22c. DATE SIGNED <u>12/19/60</u>
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>burial</u>	23b. DATE <u>12-18-60</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Darlington Cemetery</u>		23d. LOCATION (City, town, or county) (State) <u>Darlington, Missouri</u>	
24. FUNERAL DIRECTOR ADDRESS <u>BREIT & HAWKINS SAVANNAH</u>		25. DATE RECD. BY LOCAL REG. <u>12-22-60</u>	26. REGISTRAR'S SIGNATURE <u>Lillian Sparks</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 James B. Hawkins

Licensed Embalmer No. 4535

P. O. Address Savannah

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.