

JURY DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

FILED VS DEC 20 1960

-60-045328

Registration District No. 47 Primary Registration District No. 3008 Registrar's No. 322 STATE FILE NUMBER

ENDED

1. PLACE OF DEATH a. COUNTY <u>Callaway</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Randolph</u>															
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Fulton, Missouri</u>		Length of stay in 1b <u>3 Yrs</u>		c. CITY OR TOWN <u>Moberly</u>		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>													
c. FULL NAME OF (IF NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>State Hospital No. 1</u>			Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location) <u>1318 Scott Ave.</u>		Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>												
3. NAME OF DECEASED (Type or print) First Middle Last <u>Gladys Donzella Mikel</u>				4. DATE OF DEATH Month Day Year <u>Dec. 14 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>1/21/1910</u>		9. AGE (last birthday) <u>50</u>		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HR							
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Teacher - housewife</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Same</u>		11. BIRTHPLACE (City and state or country) <u>Texas County, Mo.</u>		12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>											
13a. FATHER'S NAME <u>William Arthur Young</u>				13b. MOTHER'S MAIDEN NAME <u>Emma Belle Clark</u>				14. NAME OF HUSBAND OR WIFE <u>William Roxie Mikel</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>unk</u>		17. INFORMANT Address <u>State Hospital No. 1 records Fulton, 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>Arteriosclerotic Heart Disease</u> DUE TO (b) <u>Occlusion of Abdominal Aorta.</u> DUE TO (c) <u>Gangrene left cholecystitis</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										INTERVAL BETWEEN ONSET AND DEATH									
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input 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. <input checked="" type="checkbox"/> Attended the deceased from <u>State Hospital No. 1 1957</u> to <u>1960</u> Death occurred at <u>4:30 AM</u> on the date stated above, and to the best of my knowledge, from the causes stated.																			
22a. SIGNATURE (Degree or title) <u>William V Torricelli MD</u>				22b. ADDRESS <u>State Hospital No. 1, Fulton, Mo</u>				22c. DATE SIGNED <u>12/14/60</u>											
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE <u>Dec. 16, 1960</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Wellsville</u>				23d. LOCATION (City, town, or county) (State) <u>Wellsville, Mo</u>											
24. FUNERAL DIRECTOR ADDRESS <u>Margie Jacobson Fulton, Mo.</u>				25. DATE RECD. BY LOCAL REG. <u>Dec-16-1960</u>				26. REGISTRAR'S SIGNATURE <u>Martha Lawrence</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 L. J. Rossow
Licensed Embalmer No. 2555
P. O. Address Quilicura

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.