

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

FILED VS DEC 20 1960

53

Primary Registration District No. 3010

Registrar's No. 496

60-045361

STATE FILE NUMBER

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| 1. PLACE OF DEATH<br>a. COUNTY <b>CAPE GIRARDEAU</b>   |  | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <b>MO</b> b. COUNTY <b>CAPE GIRARDEAU</b> |  |
| b. CITY (If outside corporate limits, give TOWNSHIP only)<br>OR TOWN <b>CAPE GIRARDEAU</b>                 |  | Length of stay in 1b  | c. CITY OR TOWN <b>CAPE GIRARDEAU</b>  |
| c. FULL NAME OF (If NOT in hospital, give location)<br>HOSPITAL OR INSTITUTION <b>MILLERS-NURSING HOME</b> |  | Inside Limits<br>Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>  | d. STREET ADDRESS (If outside, give location)<br>Reside on Farm<br>Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> |

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|--|--|--|--|--|
| 3. NAME OF DECEASED (Type or print)<br>First <b>MARY</b> Middle <b>CAROLINE</b> Last <b>RECTOR</b> |  |  | 4. DATE OF DEATH<br>Month <b>12</b> Day <b>10</b> Year <b>60</b> |  |
|--|--|--|--|--|

|                         |                                  |   |                                      |                                     |   |                |
|-------------------------|----------------------------------|---|--------------------------------------|-------------------------------------|---|----------------|
| 5. SEX<br><b>FEMALE</b> | 6. COLOR OR RACE<br><b>WHITE</b> | 7. Married <input type="checkbox"/> Never Married <input type="checkbox"/><br>Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/> | 8. DATE OF BIRTH<br><b>10-8-1875</b> | 9. AGE (last birthday)<br><b>85</b> | IF UNDER 1 YEAR<br>Months Days Hours Min. | IF UNDER 24 HR |
|-------------------------|----------------------------------|---|--------------------------------------|-------------------------------------|---|----------------|

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| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>AT HOME</b> | 10b. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (City and state or country)<br><b>GOLCONDA, ILL</b> | 12. CITIZEN OF WHAT COUNTRY<br><b>U.S.A.</b> |
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|---|---|--|
| 13a. FATHER'S NAME<br><b>WILLIAM NEAL</b> | 13b. MOTHER'S MAIDEN NAME<br><b>MARY VARVEL</b> | 14. NAME OF HUSBAND OR WIFE<br><b>LOWRY RECTOR</b> |
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| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)<br><b>NO</b> | 16. SOCIAL SECURITY NO. | 17. INFORMANT<br><b>Mrs Sam Jones - Cape Girardeau Mo</b> |
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| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Cerebral Concussion</b> |  | INTERVAL BETWEEN ONSET AND DEATH<br><b>36 hrs.</b> |
| Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.   | DUE TO (b) <b>Chronic Hypertensive Myocarditis</b> | <b>5 yrs</b>                                       |
| DUE TO (c)   |  |  |

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| 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.<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown |
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| 19. WAS AUTOPSY PERFORMED?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 20a. ACCIDENT <input checked="" 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.)<br><b>Fell 12/8/60 while attempting to stand</b> |
| 20c. TIME OF INJURY<br>Hour <b>8</b> p.m. Month, Day, Year <b>12-8-60</b>                         |  |   |

|   |  |   |        |       |
|---|--|---|--------|-------|
| 20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/> | 20e. PLACE OF INJURY (e.g., in or about home, factory, street, office bldg, etc.)<br><b>Millers Nursing Home</b> | 20f. CITY, TOWN, OR LOCATION<br><b>Cape Girardeau - Cape Ind. Mo.</b> | COUNTY | STATE |
|---|--|---|--------|-------|

21. I attended the deceased from **Oct. 25-60** to **Dec. 10-60** and last saw her alive on **12-2-60**  
Death occurred at **7:10 a.m.** on the date stated above, and to the best of my knowledge, from the causes stated.

|  |  |                                     |
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| 22a. SIGNATURE (Of doctor or title)<br><b>William J. Oehler M.D.</b> | 22b. ADDRESS<br><b>Cape Girardeau, Mo.</b> | 22c. DATE SIGNED<br><b>12/14/60</b> |
|--|--|-------------------------------------|

|  |                              |   |   |
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| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>BURIAL</b> | 23b. DATE<br><b>12-12-60</b> | 23c. NAME OF CEMETERY OR CREMATORY<br><b>City</b> | 23d. LOCATION (City, town, or county)<br><b>SIKESTON Mo</b> |
|--|------------------------------|---|---|

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|---|---------|---|---|
| 24. FUNERAL DIRECTOR<br><b>Welch Funeral Home - Sikeston Mo</b> | ADDRESS | 25. DATE RECD. BY LOCAL REG.<br><b>12-15-1960</b> | 26. REGISTRAR'S SIGNATURE<br><b>Gene Kasten</b> |
|---|---------|---|---|

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

DEC 21 1960

DEC 28 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 \_\_\_\_\_, Student Embalmer No. \_\_\_\_\_ or by \_\_\_\_\_, Student Embalmer No. \_\_\_\_\_ working under my personal supervision.

Student \_\_\_\_\_  
Signature of Student Embalmer

Signed

*Raymond Chews*

Licensed Embalmer No. 3467

P. O. Address Sikeston

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to 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.