

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

**=60-045394**

FILED VS DEC 19 1960

Registration District No. 59 Primary Registration District No. 4097 Registrar's No. 209 STATE FILE NUMBER

1. PLACE OF DEATH a. COUNTY <b>Cass</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Missouri</b> b. COUNTY <b>Cass</b>					
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>Harrisonville</b>		Length of stay in 1b <b>1 hour</b>		c. CITY OR TOWN <b>Harrisonville</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>			
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>Memorial Hospital</b>			Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location) <b>800 S. Independence</b>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First <b>CHARLES</b> Middle <b>RICHARD</b> Last <b>GEORGE</b>				4. DATE OF DEATH Month <b>Dec.</b> Day <b>6</b> Year <b>1960</b>					
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>		8. DATE OF BIRTH	9. AGE (last birthday) <b>72</b>	IF UNDER 1 YEAR Months	IF UNDER 24 HR Days	Hours	Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Farmer</b>			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (City and state or country) <b>Hickman Mills, Mo.</b>		12. CITIZEN OF WHAT COUNTRY <b>USA</b>		
13a. FATHER'S NAME <b>John W. George</b>			13b. MOTHER'S MAIDEN NAME <b>Dora Ruth Estes</b>			14. NAME OF HUSBAND OR WIFE <b>Martha George</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>no</b>		16. SOCIAL SECURITY NO. <b>497 36 2589</b>		17. INFORMANT <b>Mrs Martha George Harrisonville, Mo</b>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>CORONARY THROMBOSIS</b> DUE TO (b) <b>FRTERIAL SCLEROTIC HEART DISEASE</b> DUE TO (c) _____ Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.							INTERVAL BETWEEN ONSET AND DEATH		
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"/> N. <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 _____ 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. I attended the deceased from <b>1950 Dec 5, 1960</b> and last saw him alive on <b>Dec 5, 1960</b> Death occurred at _____ m on the date stated above, and to the best of my knowledge, from the causes stated.									
22a. SIGNATURE <b>[Signature]</b> (Degree or title)				22b. ADDRESS <b>Harrisonville, Mo</b>		22c. DATE SIGNED <b>Dec 7, 1960</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE <b>12-9-1960</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Orient Cemetery</b>		23d. LOCATION (City, town, or county) (State) <b>Harrisonville, Mo.</b>					
24. FUNERAL DIRECTOR <b>Atkinson D. Key Harrisonville, Mo.</b>				25. DATE RECD. BY LOCAL REG. <b>Dec 8, 1960</b>		26. REGISTRAR'S SIGNATURE <b>Mrs. Ray Sebra</b>			

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

DEC 20 1960

JAN 10 1961

**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 Robert Atkinson

Licensed Embalmer No. 4912

P. O. Address Hammock

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.