

FEDERAL DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-60-045484

FILED VS. DEC 29 1960

78

Registration District No. 5291

Registrar's No. 129

STATE FILE NUMBER

1. PLACE OF DEATH a. COUNTY Clay			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY Clay			
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Liberty		Length of stay in 1b 8 years		c. CITY OR TOWN Liberty		Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION I.O.O.F. Hospital			Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) I.O.O.F. Hospital		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Jesse Middle B. Last Southwick			4. DATE OF DEATH Month Dec. Day 13, Year 1960			
5. SEX Male	6. COLOR OR RACE White	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH 3-29-1881	9. AGE (last birthday) 79	IF UNDER 1 YEAR Months 79 Days 0	IF UNDER 24 HR Hours 0 Min. 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Farmer		10b. KIND OF BUSINESS OR INDUSTRY Farming		11. BIRTHPLACE (City and state or country) Collins, Missouri		12. CITIZEN OF WHAT COUNTRY USA
13a. FATHER'S NAME Jesse B. Southwick		13b. MOTHER'S MAIDEN NAME Doshia Rainey		14. NAME OF HUSBAND OR WIFE Laura M. Southwick		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. None		17. INFORMANT Murl Southwick, 251 1/2 E. Broadway, Excelsior Springs, Mo.		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Last stroke / Brain, heart					INTERVAL BETWEEN ONSET AND DEATH 13 days	
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) Arthritis - disabled about 7 years DUE TO (c) He was smoking - in some manner overstuff chair / accident + burned						
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) slowly for some reason not known he was not sensitive to pain in legs					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 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.)			
20c. TIME OF INJURY Hour Noon Month, Day, Year Dec 1960		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, farm, factory, street, office bldg., etc.) In his room at IOOF Home Liberty Clay Mo		20f. CITY, TOWN, OR LOCATION Liberty
21. I attended the deceased from 1954 to Dec 13 and last saw him alive on Dec 12		Death occurred at 2:50 a.m. on the date stated above, and to the best of my knowledge, from the causes stated.				
22a. SIGNATURE Wm H. Goodson M.D. (Degree or title)			22b. ADDRESS Liberty Mo		22c. DATE SIGNED 12/13/60	
23a. BURIAL, CREMATION, REMOVAL (Specify) Removal	23b. DATE 12-13-60	23c. NAME OF CEMETERY OR CREMATORY Crown Hill		23d. LOCATION (City, town, or county) (State) Excelsior Springs, Mo.		
24. FUNERAL DIRECTOR Prichard Funeral Home, Inc. ADDRESS Excelsior Springs, Missouri		25. DATE RECD. BY LOCAL REG. 12-18-60		26. REGISTRAR'S SIGNATURE Maude Graham		

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 Lindsey Jarman

Licensed Embalmer No. 4580
F. O. Address Excelsior Springs

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.