

RI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

60-045558

FILED VS DEC 20 1960

Registration District No. 86 Primary Registration District No. 4449 Registrar's No. 32-1960 STATE FILE NUMBER

DED

1. PLACE OF DEATH a. COUNTY <u>Crawford</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Crawford</u>				
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Cuba</u>		Length of stay in 1b <u>many</u> years		c. CITY OR TOWN <u>Cuba</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>Cuba Senior Citizens Home</u>			Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location) <u>704 E. Washington</u>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>William</u> Middle <u>Garfield</u> Last <u>Biselow</u>				4. DATE OF DEATH Month <u>Dec.</u> Day <u>14</u> Year <u>1960</u>				
5. SEX <u>male</u>	6. COLOR OR RACE <u>White</u>	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>		8. DATE OF BIRTH <u>July 27 1880</u>	9. AGE (last birthday) <u>80</u>	IF UNDER 1 YEAR Months _____ Days _____	IF UNDER 24 HR Hours _____ Min. _____	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Carpenter Contractor</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>Retired</u>		11. BIRTHPLACE (City and state or country) <u>Madison Co. Ohio</u>		12. CITIZEN OF WHAT COUNTRY <u>U. S. A.</u>	
13a. FATHER'S NAME <u>Samuel Biselow</u>			13b. MOTHER'S MAIDEN NAME <u>Cynthia Shephard</u>			14. NAME OF HUSBAND OR WIFE <u>Alma Wilburn-Deed</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>NOT Available</u>		17. INFORMANT <u>Dr. Norman C. Hoener</u> Address <u>Cuba, Mo.</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY:							INTERVAL BETWEEN ONSET AND DEATH	
IMMEDIATE CAUSE (a) <u>Hypoglycemia from insulin</u>							<u>4 hrs</u>	
DUE TO (b) <u>Diabetes Mellitus</u>							<u>30 yrs.</u>	
DUE TO (c)								
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>Cerebral arteriosclerosis</u>							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 _____ a.m. _____ p.m.		Month, Day, Year						
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.)		20f. CITY, TOWN, OR LOCATION		COUNTY		STATE
21. I attended the deceased from <u>Sept 1958</u> to <u>Sept 1960</u> and last saw him alive on <u>Dec 13, 1960</u>				Death occurred at <u>2:30 a.m.</u> on the date stated above, and to the best of my knowledge, from the causes stated.				
22a. SIGNATURE <u>Frank W. Stiers, MD</u> (Describe or title)				22b. ADDRESS <u>Cuba Mo</u>			22c. DATE SIGNED <u>12/14/60</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE <u>12-17-1960</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Kinden</u>		23d. LOCATION (City, town, or county) <u>Cuba</u>		STATE <u>MO.</u>		
24. FUNERAL DIRECTOR <u>Norman C. Hoener</u> ADDRESS <u>Cuba, Mo.</u>			25. DATE RECD. BY LOCAL REG. <u>12-17-1960</u>		26. REGISTRAR'S SIGNATURE <u>[Signature]</u>			

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

DEC 21 1960

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

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

Signed Norman L. Trane

Licensed Embalmer No. 467

P. O. Address Oshtemo, Ia

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.