

# URI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

FILED VS DEC 19 1960

-60-045767

STATE FILE NUMBER

Registration District No. 128 Primary Registration District No. 2000 Registrar's No. 1230

ENDED

1. PLACE OF DEATH a. COUNTY <b>GREENE</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MO</b> b. COUNTY <b>WEBSTER</b>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>SPRINGFIELD</b>	Length of stay in 1b <b>10 DAYS</b>	c. CITY OR TOWN <b>FORD AND MO RI</b>	Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>MERCY Hoop</b>		d. STREET ADDRESS (If outside, give location) <b>4MI N.E.</b>	Reside on Farm Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>

3. NAME OF DECEASED (Type or print) First <b>MARY</b> Middle <b>SWEET</b> Last			4. DATE OF DEATH Month <b>DEC</b> Day <b>10</b> Year <b>1960</b>			
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5. SEX <b>FEMALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <b>1-7-1897</b>	9. AGE (last birthday) <b>83</b>	IF UNDER 1 YEAR 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) <b>HOUSEWIFE</b>		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and state or country) <b>INDIANA</b>	12. CITIZEN OF WHAT COUNTRY <b>U.S.A</b>	
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13a. FATHER'S NAME <b>WILLIAM CONRAD</b>		13b. MOTHER'S MAIDEN NAME <b>MARGARET MEYER</b>		14. NAME OF HUSBAND OR WIFE	
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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) <b>NO</b>	16. SOCIAL SECURITY NO.	17. INFORMANT Address <b>MRS L.E. CASS FORD AND RI</b>			
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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>Congestive Heart Failure</b>			INTERVAL BETWEEN ONSET AND DEATH <b>2 years</b>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) <b>Arteriosclerotic Cardiovascular Disease</b>	<b>5-6 years</b>	
	DUE TO (c) <b>Peripheral Vascular insufficiency</b>	<b>5 years</b>	

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <b>Degenerative arthritis.</b>		PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown	
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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.)			
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20c. TIME OF INJURY Hour Month, Day, Year a.m. p.m.					
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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
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21. I attended the deceased from **May 26, 1955** to **Dec 10, 1960** and last saw her <sup>him</sup> alive on **Nov. 9, 1960**  
Death occurred at **6:00 P.m.** on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) <b>J. M. McDonnell M.D.</b>		22b. ADDRESS <b>Marshfield, Mo.</b>		22c. DATE SIGNED <b>3 Dec 60</b>
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23a. BURIAL, CREMATION, REMOVAL (Specify) <b>REMOVAL</b>	23b. DATE <b>12-10-1960</b>	23c. NAME OF CEMETERY OR CREMATORY <b>MARSHFIELD</b>	23d. LOCATION (City, town, or county) (State) <b>MARSHFIELD MO</b>	
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24. FUNERAL DIRECTOR ADDRESS <b>BARBER-EDWARDS MARSHFIELD</b>		25. DATE RECD. BY LOCAL REG. <b>12-15-60</b>	26. REGISTRAR'S SIGNATURE <b>Effie S. Melton</b>	
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(Licensed Embalmer's Statement on Reverse Side)

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

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

Signed George Stapf

Licensed Embalmer No. 316

P. O. Address Mt. View

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.