

RI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-60-045826

DEC 27 1960

STATE FILE NUMBER

Registration District No. 137 Primary Registration District No. 3023 Registrar's No. 318

DEED

1. PLACE OF DEATH a. COUNTY <u>Henry</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. <u>Missouri</u> b. COUNTY <u>Henry</u>									
b. CITY (If outside corporate limits, give TOVNSHIP only) <u>Clinton</u>		Length of stay in 1b <u>1 day</u>		c. CITY OR TOWN <u>Clinton</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>Clinton Gen. Hosp.</u>			Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location) <u>East Jefferson</u>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>						
3. NAME OF DECEASED (Type or print) First <u>John</u> Middle <u>JAMES</u> Last <u>MASTRIES</u>				4. DATE OF DEATH Month <u>Dec.</u> Day <u>16</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>12-5-1879</u>		9. AGE (last birthday) <u>81</u>		IF UNDER 1 YEAR Months <u>0</u> Days <u>12</u>		IF UNDER 24 HR Hours <u>-</u> Min. <u>-</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired General Director</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Funeral</u>		11. BIRTHPLACE (City and state or country) <u>Missouri</u>		12. CITIZEN OF WHAT COUNTRY <u>USA</u>					
13a. FATHER'S NAME <u>John A. Mastries</u>				13b. MOTHER'S MAIDEN NAME <u>Nancy Ann Ashby</u>				14. NAME OF HUSBAND OR WIFE <u>Deceased</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>573-32-1941</u>		17. INFORMANT <u>Ruth Smith</u> Address <u>Clinton Mo</u>							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>cerebral hemorrhage</u> DUE TO (b) _____ DUE TO (c) _____ Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.										INTERVAL BETWEEN ONSET AND DEATH <u>4 days</u>			
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"/> 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 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>1958</u> to <u>Dec. 16, 1960</u> and last saw ^{her} <u>him</u> alive on <u>Dec. 16, 1960</u> Death occurred at <u>6:30 p</u> on the date stated above, and to the best of my knowledge, from the causes stated.													
22a. SIGNATURE (Degree or title) <u>Hugh B. Walker, MD</u>						22b. ADDRESS <u>Clinton, Mo.</u>			22c. DATE SIGNED <u>12-20-60</u>				
23a. BURIAL, CREMATION, REMOVAL (specify) <u>Burial</u>		23b. DATE <u>12/19/60</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Englewood</u>		23d. LOCATION (City, town, or county) <u>Clinton Mo</u>		(State)					
24. FUNERAL DIRECTOR <u>F.L. SCHABERG</u> ADDRESS <u>CLINTON MO</u>				25. DATE RECD. BY LOCAL REG. <u>Dec. 20, 1960</u>		26. REGISTRAR'S SIGNATURE <u>Mildred Bigans</u>							

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

Student _____
Signature of Student Embalmer

Signed F. L. Schobert

Licensed Embalmer No. 451

P. O. Address Clinton

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.