URI DIVISION OF HEALTH – STANDARD CERTIFICATE OF DEATH

FILED VS DEC 1 9 1960

-60-045860
STATE FILE NUMBER

Registration District No. 141 Primary Registration District No. 3025 Registrar's No. 176

1. PLACE OF DEATH
a. COUNTY Howell
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN West Plains — Length of stay in 1b 45
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Rt 3 — Inside Limits Yes ☐ No ☑

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Mo., b. COUNTY Howell
c. CITY OR TOWN West Plains — Inside Limits Yes ☑ No ☐
d. STREET ADDRESS Rt 3 (If outside, give location) — Reside on Farm Yes ☑ No ☐

3. NAME OF DECEASED (Type or print) First Jno. Middle N. Last Drinnon
4. DATE OF DEATH Month 12 Day 5 Year 60

5. SEX M
6. COLOR OR RACE W
7. Married ☐ Never Married ☐ Widowed ☑ Divorced ☐
8. DATE OF BIRTH 12-15-78
9. AGE (last birthday) 91
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) Farmer
10b. KIND OF BUSINESS OR INDUSTRY ✓
11. BIRTHPLACE (City and state or country) West Plains Mo
12. CITIZEN OF WHAT COUNTRY USA

13a. FATHER'S NAME Joe Drinnon
13b. MOTHER'S MAIDEN NAME Frances Curtis
14. NAME OF HUSBAND OR WIFE ✓

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) ✓ (If yes, give war or dates of service)
16. SOCIAL SECURITY NO. ✓
17. INFORMANT Joe Drinnon Address West Plains Mo

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Cerebral Hemorrhage — INTERVAL BETWEEN ONSET AND DEATH Weeks
DUE TO (b) Cerebral Arteriosclerosis
DUE TO (c)
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)
(1) Arteriosclerosis generalized (2) senility

PART III. If deceased was female was there a pregnancy in last 90 days. ☐ Yes ☐ No ☐ Unknown

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☑
20a. ACCIDENT ☐ SUICIDE ☐ HOMICIDE ☐
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 ☐ NOT WHILE AT WORK ☐
20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
20f. CITY, TOWN, OR LOCATION COUNTY STATE

BY AFFIDAVIT OF

21. I attended the deceased from 10-30-60 to 12-5-60 and last saw ~~her~~ him alive on 12-2-60
Death occurred at 12:30 a. m. on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE R. L. Wiles M.D. (Degree or title)
22b. ADDRESS West Plains Mo.
22c. DATE SIGNED 12-9-60

23a. BURIAL, CREMATION, REMOVAL (Specify) Burial
23b. DATE 12-8-60
23c. NAME OF CEMETERY OR CREMATORY Howell Valley
23d. LOCATION (City, town, or county) West Plains (State) Mo

24. FUNERAL DIRECTOR Robertson ADDRESS West Plains Mo
25. DATE RECD. BY LOCAL REG. 12-14-60
26. REGISTRAR'S SIGNATURE Beatrice Cook

(Licensed Embalmer's Statement on Reverse Side)

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_____ Signed_____

Signature of Student Embalmer

Licensed Embalmer No._____

P. O. Address_____

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to co
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.