

JRI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-60-045864

REGISTRATION DISTRICT NO. 141

PRIMARY REGISTRATION DISTRICT NO. 5551 REGISTRAR'S NO. 183

STATE FILE NUMBER

1. PLACE OF DEATH a. COUNTY <u>Howell</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Mo</u> b. COUNTY <u>Howell</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>West Plains,</u>		Length of stay in 1b <u>5 yrs.</u>	c. CITY OR TOWN <u>West Plains,</u> Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>Lebo Rte.,</u>		Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <u>Lebo Rte.,</u> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print) First <u>Mary Jane</u> Middle <u>Ipock</u> Last <u></u>			4. DATE OF DEATH Month <u>Dec.</u> Day <u>7th.</u> Year <u>1960</u>				
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</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>4-18-73</u>	9. AGE (last birthday) <u>87</u>	IF UNDER 1 YEAR IF UNDER 24 HR Months Days Hours Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>House</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>x</u> <u>x</u>		11. BIRTHPLACE (City and state or country) <u>Dent Co., Mo</u>		12. CITIZEN OF WHAT COUNTRY <u>USA</u>	
13a. FATHER'S NAME <u>Alex Jennison</u>		13b. MOTHER'S MAIDEN NAME <u>Elizabeth Brooks</u>		14. NAME OF HUSBAND OR WIFE <u>x</u> <u></u> <u>x</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <input checked="" type="checkbox"/>		16. SOCIAL SECURITY NO. <u>x</u>		17. INFORMANT Address <u>Jasper Ipock, West Plains, 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 Vascular Thrombosis</u> 8 hrs		INTERVAL BETWEEN ONSET AND DEATH <u>10 yrs</u>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) <u>Arteriosclerosis</u>	
	DUE TO (c) <u>Senility</u>	

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>Previous episodes of Cerebral Apoplexy</u>		PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> N. <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.)	
20c. TIME OF INJURY Hour <u></u> Month, Day, Year <u></u> a.m. p.m.	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 10-10-1960 to 12-7-1960 and last saw her him alive on 12-7-1960
Death occurred at 2:15 Am on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) <u>Murray R. Pritchard MD</u>		22b. ADDRESS <u>913 W Main West Plains, Mo.</u>		22c. DATE SIGNED <u>12-15-60</u>
23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE <u>12-9-60</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Summers</u>	23d. LOCATION (City, town, or county) (State) <u>Eminence Mo</u>	
24. FUNERAL DIRECTOR ADDRESS <u>Robertsons, West Plains, Mo</u>		25. DATE RECD. BY LOCAL REG. <u>12-19-60</u>	26. REGISTRAR'S SIGNATURE <u>Beatrice Cook</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 by
or by _____, Student Embalmer No. _____
working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed

J. A. Roberts

Licensed Embalmer No. 343

P. O. Address Wesley

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.