

**FURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH**

**-60-045867**

**FILED VS DEC 19 1960**

STATE FILE NUMBER

Registration District No. 141 Primary Registration District No. 5554 Registrar's No. 175

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>Petersville</u>	Length of stay in 1b <u>4rs</u>	c. CITY OR TOWN <u>Petersville</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 <input checked="" type="checkbox"/>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print) First <u>Aueanda</u> Middle <u>M.</u> Last <u>Thomas</u>			4. DATE OF DEATH Month <u>12</u> Day <u>4</u> Year <u>60</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>5-30-83</u>	9. AGE (last birthday) <u>77</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>Housewife</u>	10b. KIND OF BUSINESS OR INDUSTRY <input checked="" type="checkbox"/>	11. BIRTHPLACE (City and state of country) <u>Howell Co. Mo</u>	12. CITIZEN OF WHAT COUNTRY <u>USA</u>
---	--	--	---

13a. FATHER'S NAME <u>Joshua Dooley</u>	13b. MOTHER'S MAIDEN NAME <u>Leelia Poppit</u>	14. NAME OF HUSBAND OR WIFE <input checked="" type="checkbox"/>
--	---	--

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <input checked="" type="checkbox"/>	16. SOCIAL SECURITY NO. <u>117</u> INFORMANT <u>Waldie Bricker</u> Address <u>Petersville, 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>		INTERVAL BETWEEN ONSET AND DEATH <u>3 weeks</u>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) <u>Cerebral Arteriosclerosis</u>	
	DUE TO (c)	

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal phase, condition (e.g., I (a)) <u>Fractured Hip &amp; Senility</u>	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
---	---

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.) <u>None</u>
---	---	---

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 <u>Petersville Mo</u>	COUNTY _____ STATE _____
--	--	---	--------------------------

21. I attended the deceased from 6:50 12-52 to 12-4-60 and last saw her live on 11-3-60  
Death occurred at \_\_\_\_\_ m on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE <u>Charles Wilson, M.D.</u> (Degree or title)	22b. ADDRESS <u>West Plains, Mo</u>	22c. DATE SIGNED <u>12-9-60</u>
---	--	------------------------------------

23a. BURIAL, CREMATION, REINTERMENT (Specify) <u>Reinterment</u>	23b. DATE <u>12-7-60</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Petersville</u>	23d. LOCATION (City, town, or county) (State) <u>Petersville Mo</u>
---	-----------------------------	--	--

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

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

JAN 17 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 \_\_\_\_\_ or by \_\_\_\_\_, Student Embalmer No. \_\_\_\_\_ working under my personal supervision.

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

Signed *H. J. Roberts*

Licensed Embalmer No. 3432

P. O. Address *Leesville*

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