

RI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-60-046521

EC 27 1960

Registration District No. 157 Primary Registration District No. 3028 Registrar's No. 256

STATE FILE NUMBER

IDED

1. PLACE OF DEATH a. COUNTY <u>Jasper</u>			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> COUNTY <u>Jasper</u>			
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Carthage</u>		Length of stay in 1b <u>4 wks.</u>	c. CITY OR TOWN <u>Arifwa</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>McCone - Brooks</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <u>R. F. D.</u>		Reside on Farm Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Alma</u> Middle <u>Zeta</u> Last <u>Austin</u>			4. DATE OF DEATH Month <u>12</u> Day <u>19</u> Year <u>1960</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>white</u>	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <u>3-31-1884</u>	9. AGE (last birthday) <u>76</u>	IF UNDER 1 YEAR Months <u>8</u> Days <u>18</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even, if retired) <u>house wife</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (City and state or country) <u>Lawrence Co.</u>	12. CITIZEN OF WHAT COUNTRY <u>USA</u>	
13a. FATHER'S NAME <u>L. J. Adamson</u>		13b. MOTHER'S MAIDEN NAME <u>Alice Harshbarger</u>		14. NAME OF HUSBAND OR WIFE <u>Bibb Austin</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>498-44-6889</u>	17. INFORMANT <u>Mr. Bill Austin</u>		Address <u>Avilla Mo.</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY:					INTERVAL BETWEEN ONSET AND DEATH	
IMMEDIATE CAUSE (a) <u>Encephalomalacia</u>					1 mon.	
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.					5wks	
DUE TO (b) <u>Cerebral thrombosis</u>						
DUE TO (c)						
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>11/21/60</u> to <u>12/19/60</u> and last saw her alive on <u>12/19/60</u> Death occurred at <u>3:00</u> <u>A.M.</u> on the date stated above, and to the best of my knowledge, from the causes stated.						
22a. SIGNATURE <u>Charles L. Schell, M.D.</u> (Degree or title)			22b. ADDRESS <u>1515 Hazel, Carthage, Mo.</u>		22c. DATE SIGNED <u>12/21/60</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE <u>12-21-1960</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Summit</u>	23d. LOCATION (City, town, or county) <u>S. E. Miller Mo.</u>		(State)	
24. FUNERAL DIRECTOR <u>Monica - Senior Miller Mo.</u> ADDRESS		25. DATE RECD. BY LOCAL REG. <u>12-21-60</u>	26. REGISTRAR'S SIGNATURE <u>Bill Austin</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

G. A. Seaman

Licensed Embalmer No. 3297

P. O. Address Miller 2

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.