

RID DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-60-046745

LED VS DEC 23 1960

Registration District No. 385 Primary Registration District No. 3039 Registrar's No. 166

STATE FILE NUMBER

DED

1. PLACE OF DEATH a. COUNTY <u>LINN</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Mo</u> b. COUNTY <u>LINN</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>MARCELINE</u>		c. CITY OR TOWN <u>MARCELINE</u>	
Length of stay in 1b		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>ST. FRANCIS HOSP</u>		d. STREET ADDRESS (If outside, give location) <u>215 W. WALKER</u>	
Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	

3. NAME OF DECEASED (Type or print) First <u>ALLIE</u> Middle <u>E.</u> Last <u>SCOTT</u>			4. DATE OF DEATH Month <u>DEC</u> Day <u>9</u> Year <u>1960</u>			
5. SEX <u>FEMALE</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>5-15-1876</u>	9. AGE (last birthday) <u>84</u>	IF UNDER 1 YEAR Months <u>6</u> Days <u>24</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>HOUSEWIFE</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Home</u>		11. BIRTHPLACE (City and state or country) <u>Chariton Co.</u>		12. CITIZEN OF WHAT COUNTRY <u>USA</u>
13a. FATHER'S NAME <u>JOHN F. CONRAD</u>		13b. MOTHER'S MAIDEN NAME <u>MARGARET Mc DANIEL</u>		14. NAME OF HUSBAND OR WIFE <u></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>NONE</u>		17. INFORMANT <u>John F. Scott</u> Address <u>KIRKSVILLE 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>Cerebral Vascular Accident, Auto</u>		<u>26 hrs</u>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) <u>Generalized Arteriosclerosis</u>	<u>indefinite</u>
DUE TO (c) <u></u>		<u></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	
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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> a.m. <u></u> p.m. <u></u> Month, Day, Year <u></u>	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>6 Dec 60</u> to <u>8 Dec 60</u> and last saw ^{her} him alive on <u>8 Dec 60</u> Death occurred at <u>6:45 pm</u> on the date stated above, and to the best of my knowledge, from the causes stated.			

22a. SIGNATURE (Deedee or title) <u>Blenna A. Home, M.D.</u>		22b. ADDRESS <u>Marceline, Mo</u>		22c. DATE SIGNED <u>9 Dec 60</u>
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	23b. DATE <u>12-11-60</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Mt. Olivet Cem</u>		23d. LOCATION (City, town, or county) (State) <u>MARCELINE Mo</u>
24. FUNERAL DIRECTOR <u>Miller-Tillotson</u>		ADDRESS <u>MARCELINE Mo</u>	25. DATE RECD. BY LOCAL REG. <u>12-10-60</u>	26. REGISTRAR'S SIGNATURE <u>Brownie Owens</u>

(Licensed Embalmer's Statement on Reverse Side)

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

GLENDA A HOIRWEIR M.D.

VS DEC 9 0 1960

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 Lilburn K. Teal

Licensed Embalmer No. 4508

P. O. Address Marion

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