

JURY DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-60-046793

FILED VS JAN 4 1961 206

Registration District No. _____ Primary Registration District No. 5747 Registrar's No. 59

STATE FILE NUMBER

ENDED

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|---|-------------------------------------|---|---|--|--|--|--|
| 1. PLACE OF DEATH a. COUNTY <u>MADISON</u> b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>MAYOLA MO</u> Length of stay in 1b _____ c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION _____ Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/> | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MO</u> b. COUNTY <u>MADISON</u> c. CITY OR TOWN <u>MAYOLA MO</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> d. STREET ADDRESS (If outside, give location) _____ Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/> | | | |
| 3. NAME OF DECEASED (Type or print) First Middle Last <u>Columbus W Combs</u> | | | 4. DATE OF DEATH Month Day Year <u>12-27-1960</u> | | | | |
| 5. SEX <u>M</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>6-30-1874</u> | 9. AGE (last birthday) <u>88</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) _____ | | 10b. KIND OF BUSINESS OR INDUSTRY <u>Retail</u> | | 11. BIRTHPLACE (City and state or country) <u>MADISON MO</u> | | 12. CITIZEN OF WHAT COUNTRY <u>USA</u> | |
| 13a. FATHER'S NAME <u>Folia Combs</u> | | 13b. MOTHER'S MAIDEN NAME <u>CANTY</u> | | 14. NAME OF HUSBAND OR WIFE <u>MARGARET COMBS (DOW)</u> | | 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) 16. SOCIAL SECURITY NO. 17. INFORMANT Address <u>Henry Combs MAYOLA 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>NATURAL CAUSES</u> DUE TO (b) _____ DUE TO (c) _____ Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. | | | | | | INTERVAL BETWEEN ONSET AND DEATH <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 | | |
| 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 _____ to _____ and last saw her/him alive on _____ Death occurred at <u>4.00 A</u> on the date stated above, and to the best of my knowledge, from the causes stated. | |
| 22a. SIGNATURE (Degree or title) <u>Ray Wilson Coroner</u> | | | 22b. ADDRESS <u>Frederickton mo</u> | | | 22c. DATE SIGNED <u>12-27-60</u> | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <u>12/29/60</u> | | 23b. DATE <u>12/29/60</u> | | 23c. NAME OF CEMETERY OR CREMATORY <u>YOUNG CEM</u> | | 23d. LOCATION (City, town, or county) (State) <u>MADISON MO</u> | |
| 24. FUNERAL DIRECTOR ADDRESS <u>Edna Margaret MO</u> | | | 25. DATE RECD. BY LOCAL REG. <u>12-29-1960</u> | | 26. REGISTRAR'S SIGNATURE <u>Florence Hicks</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 me
or by _____, Student Embalmer No. _____

working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed Raymond B. Wula

Licensed Embalmer No. 4887

P. O. Address Fredonia

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.