

# RI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

FILED VS DEC 19 1960 254

-60-046960

STATE FILE NUMBER

Registration District No. 254 Primary Registration District No. 4386 Registrar's No. 3

1. PLACE OF DEATH a. COUNTY <b>OREGON</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MISSOURI</b> b. COUNTY <b>OREGON</b>			
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>THAYER</b>			Length of stay in 1b <b>LIFE</b>		c. CITY OR TOWN <b>THAYER</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION			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 checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <b>ED</b> Middle <b>LEE</b> Last <b>DAWSON</b>				4. DATE OF DEATH Month <b>DEC.</b> Day <b>5</b> Year <b>1960</b>			
5. SEX <b>MALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <b>1-10-1892</b>	9. AGE (last birthday) <b>68</b>	IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HR Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>retired</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>RETIRED</b>		11. BIRTHPLACE (City and state or country) <b>THAYER, MISSOURI</b>		12. CITIZEN OF WHAT COUNTRY <b>U.S.A.</b>	
13a. FATHER'S NAME <b>JIM DAWSON</b>			13b. MOTHER'S MAIDEN NAME <b>MISSOURI E. COX</b>		14. NAME OF HUSBAND OR WIFE <b>EMMA WILLIAMS (deceased)</b>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>NO NONE</b>			16. SOCIAL SECURITY NO. <b>513-16-1303</b>		17. INFORMANT Address <b>MRS. MORRIS JOHNSON, THAYER, MISSOURI</b>		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Lobar Pneumonia</b> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <b>Cerebral Hemorrhage</b> DUE TO (c) <b>Hypertension &amp; Atherosclerosis</b>						INTERVAL BETWEEN ONSET AND DEATH <b>4 day</b> <b>4 day</b>	
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 <b>Dec 1 1960</b> to <b>Dec 5 1960</b> and last saw him alive on <b>Dec 5 1960</b> Death occurred at <b>5:45 P.</b> on the date stated above, and to the best of my knowledge, from the causes stated.							
22a. SIGNATURE (Degree or title) <b>Ed Dawson MD</b>				22b. ADDRESS <b>Thayer Mo</b>		22c. DATE SIGNED	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		23b. DATE <b>12-8-60</b>		23c. NAME OF CEMETERY OR CREMATORY <b>CLIFTON CEMETERY</b>		23d. LOCATION (City, town, or county) (State) <b>THAYER, MISSOURI</b>	
24. FUNERAL DIRECTOR <b>CARTER FUNERAL HOME, THAYER, MO.</b>				25. DATE RECD. BY LOCAL REG. <b>12-14-1960</b>		26. REGISTRAR'S SIGNATURE <b>Arthur Wolff</b>	

(Licensed Embalmer's Statement on Reverse Side)

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

*Leland Carter*

Licensed Embalmer No. 4516

P. O. Address

*West Plains*

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.