

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

**-60-047109**

FILED VS  
ENDED

JAN 13 1961  
Registration District No. \_\_\_\_\_

290

Primary Registration District No. \_\_\_\_\_

Registrar's No. 167

STATE FILE NUMBER

1. PLACE OF DEATH a. COUNTY <b>Pulaski</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Missouri</b> b. COUNTY <b>Texas</b>									
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>Ft Leonard Wood</b>		Length of stay in 1b		c. CITY OR TOWN <b>Willow Springs</b>		Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>							
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>US Army Hospital</b>			Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location) <b>Star Route</b>		Reside on Farm Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>						
3. NAME OF DECEASED (Type or print) First <b>JOHN</b> Middle <b>WILLIAM</b> Last <b>OXLEY</b>				4. DATE OF DEATH Month <b>December</b> Day <b>21</b> Year <b>1960</b>									
5. SEX <b>Male</b>		6. COLOR OR RACE <b>Cau</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>28 May 1866</b>		9. AGE (last birthday) <b>94</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)			10b. KIND OF BUSINESS OR INDUSTRY <b>Farmer</b>		11. BIRTHPLACE (City and state or country) <b>Newton, Iowa</b>			12. CITIZEN OF WHAT COUNTRY <b>USA</b>					
13a. FATHER'S NAME <b>Unknown</b>				13b. MOTHER'S MAIDEN NAME <b>Unknown</b>				14. NAME OF HUSBAND OR WIFE <b>Cora Emeline</b>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>			16. SOCIAL SECURITY NO. <b>None</b>		17. INFORMANT Address <b>Virgil E. Oxley, Star Rt, Willow Spgs, Mo.</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>Bilateral bronchial pneumonia</b>										INTERVAL BETWEEN ONSET AND DEATH			
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.		DUE TO (b) <b>Subphrenic abscess</b>											
		DUE TO (c) <b>Perforated gastric ulcer</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 checked="" type="checkbox"/> NO <input 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>25 November 1960</b> to <b>21 December 1960</b> last saw <del>him</del> <sup>her</sup> <b>live</b> on <b>21 December 1960</b> Death occurred at <b>4:10 P.</b> m on the date stated above, and to the best of my knowledge, from the causes stated.													
22a. SIGNATURE <b>James T. Adams, Captain, MC</b>				22b. ADDRESS <b>US Army Hospital Fort Leonard Wood, Missouri</b>				22c. DATE SIGNED <b>22 Dec 60</b>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Removal</b>		23b. DATE <b>12/23/1960</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Sargeant Cemetery</b>			23d. LOCATION (City, town, or county) (State) <b>Crosswell North Dakota</b>						
24. FUNERAL DIRECTOR <b>MOSS-WILLIAMS FUNERAL HOMES INC</b>				ADDRESS		25. DATE RECD. BY LOCAL REG. <b>12-23-60</b>		26. REGISTRAR'S SIGNATURE <i>[Signature]</i>					

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 \_\_\_\_\_

Licensed Embalmer No. \_\_\_\_\_

P. O. Address \_\_\_\_\_

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