

FRI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-60-047152

FILED VS DEC 29 1960

Registration District No. 294 Primary Registration District No. 6009 Registrar's No. 308

STATE FILE NUMBER

1. PLACE OF DEATH a. COUNTY <u>Randolph</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Randolph</u>					
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Madison Salt River Life</u>		Length of stay in lb <u>Life</u>		c. CITY OR TOWN <u>Madison</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>Madison RFD #1</u>			Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>		d. STREET ADDRESS (If outside, give location) <u>RFD #1</u>		Reside on Farm Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First <u>JOHN FRANKLIN</u> Middle <u>GAINES</u> Last <u>GAINES</u>				4. DATE OF DEATH Month <u>December</u> - Day <u>21</u> - Year <u>1960</u>					
5. SEX <u>Male</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>5-26-78</u>	9. AGE (last birthday) <u>82</u>	IF UNDER 1 YEAR Months <u> </u> Days <u> </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>Farmer</u>			10b. KIND OF BUSINESS OR INDUSTRY <u> </u>		11. BIRTHPLACE (City and state or country) <u>Cairo Missouri</u>		12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>		
13a. FATHER'S NAME <u>Frank Gaines</u>			13b. MOTHER'S MAIDEN NAME <u>Elna Halliburton</u>			14. NAME OF HUSBAND OR WIFE <u>Maggie Gaines</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>292-42-5257</u>		17. INFORMANT <u>Symore Gaines</u> Address <u>Madison 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>Arteriosclerotic Heart Disease</u>							INTERVAL BETWEEN ONSET AND DEATH <u>1hr</u>		
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <u> </u> DUE TO (c) <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 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> Month, Day, Year <u> </u> a.m. <u> </u> p.m. <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>July 3rd</u> to <u>Nov 4th</u> and last saw her/him alive on <u>Nov 4th</u> Death occurred at <u>9:00 A</u> on the date stated above, and to the best of my knowledge, from the causes stated.									
22a. SIGNATURE <u>Phos. S. Fleming</u> (Signature or title) <u>MD</u>				22b. ADDRESS <u>Moberly Mo</u>			22c. DATE SIGNED <u>12/22-60</u>		
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Cremated</u>		23b. DATE <u>12-23-60</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Oakland</u>			23d. LOCATION (City, town, or county) (State) <u>Moberly Mo.</u>			
24. FUNERAL DIRECTOR <u>Cater Funeral Home</u> ADDRESS <u>Moberly Mo.</u>				25. DATE RECD. BY LOCAL REG. <u>12-23-60</u>		26. REGISTRAR'S SIGNATURE <u>Seabedlow</u>			

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

JAN 29 1963

VS DEC 30 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

R. M. Cater

Licensed Embalmer No.

4117

P. O. Address

Moberly Mo

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.