

RI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-60-048423

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STATE FILE NUMBER

DED

Registration District No. Primary Registration District No. Registrar's No.

1. PLACE OF DEATH a. COUNTY Schuyler				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY Schuyler				
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Salt River		Length of stay in 1b		c. CITY OR TOWN Queen City		Inside Limits Yes ☐ No ☒		
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION 9 mi.S.E. of Queen City			Inside Limits Yes ☐ No ☒		d. STREET ADDRESS (If outside, give location) 9 mi.S.E. of Queen City		Reside on Farm Yes ☒ No ☐	
3. NAME OF DECEASED (Type or print) First Middle Last Daisy Brooking				4. DATE OF DEATH Month Day Year November 16 1960				
5. SEX Female		6. COLOR OR RACE White		7. Married ☐ Never Married ☐ Widowed ☒ Divorced ☐		8. DATE OF BIRTH 8-31-1875		
				9. AGE (last birthday) 85		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) Housewife				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (City and state or country) Randolph Co., Indiana		
						12. CITIZEN OF WHAT COUNTRY U.S.A.		
13a. FATHER'S NAME William Champ				13b. MOTHER'S MAIDEN NAME Cindy Hollowell		14. NAME OF HUSBAND OR WIFE Orla Brooking		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No				16. SOCIAL SECURITY NO. 313-18-2092		17. INFORMANT Orla Brooking, Queen City, Missouri		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Thrombosis Cerebral Arteriosclerosis Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) - DUE TO (c) - PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) Generalized Atherosclerosis PART III. If deceased was female was there a pregnancy in last 90 days. ☐ Yes ☐ No ☐ Unknown								
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒		20a. ACCIDENT ☐ SUICIDE ☐ HOMICIDE ☐		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 ☐ NOT WHILE AT WORK ☒		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 3/1/59 to 11/16/60 and last saw her alive on 11/12/60 Death occurred at 10:50 p.m. on the date stated above, and to the best of my knowledge, from the causes stated.								
22a. SIGNATURE Edward M. Roberts, M.D.				22b. ADDRESS Queen City, Mo.		22c. DATE SIGNED 11-17-60		
23a. BURIAL, CREMATION, REMOVAL (Specify) Removal		23b. DATE 11-17-60		23c. NAME OF CEMETERY OR CREMATORY Lawndale Cemetery		23d. LOCATION (City, town, or county) (State) Ridgeville, Indiana		
24. FUNERAL DIRECTOR [Signature]				25. DATE RECD. BY LOCAL REG. 12-16-60		26. REGISTRAR'S SIGNATURE Mrs. A. J. Drake		

(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 _____

Licensed Embalmer No. _____

P. O. Address _____

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.