

# RI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-60-048478

FILED VS JAN 6 1961

240

Primary Registration District No. 6149

Registrar's No. 110

STATE FILE NUMBER

INDEXED

1. PLACE OF DEATH a. COUNTY <b>Stoddard</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Mo</b> b. COUNTY <b>Stoddard</b>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>KINDER</b>	Length of stay in 1b <b>20 yrs</b>	c. CITY OR TOWN <b>Kinder</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>Star Route</b>	Inside Limits Yes <input type="checkbox"/> No <input checked="" 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>Julia</b> Middle <b>Lestine</b> Last <b>Loyd</b>			4. DATE OF DEATH Month <b>Dec.</b> Day <b>19,</b> Year <b>1960</b>	
5. SEX <b>FEMALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <b>9-10-1879</b>	9. AGE (last birthday) <b>81</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOUSE WIFE</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>HOUSEHOLD</b>	11. BIRTHPLACE (City and state or country) <b>Bollinger County, Mo</b>	12. CITIZEN OF WHAT COUNTRY <b>U. SA.</b>
13a. FATHER'S NAME <b>John DENNIS</b>		13b. MOTHER'S MAIDEN NAME <b>ANGELINE JACKSON</b>		14. NAME OF HUSBAND OR WIFE <b>OSCAR Loyd</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>OSCAR Loyd, Route, Kinder, Mo.</b>	

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY:			INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a) <b>Metastatic ca of the liver</b>		<b>3 months</b>	
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) <b>Ca of the colon</b>	<b>1 year</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)		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	
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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 \_\_\_\_\_ m on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Of doctor or other) <i>[Signature]</i>	22b. ADDRESS	22c. DATE SIGNED
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23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>	23b. DATE <b>12-22-1960</b>	23c. NAME OF CEMETERY OR CREMATORY <b>BRUSH CREEK CEMETERY</b>	23d. LOCATION (City, town, or county) (State) <b>Bollinger County, Mo.</b>
24. FUNERAL DIRECTOR <b>W<sup>m</sup> A. Morgan, Advance, Mo.</b>	25. DATE RECD. BY LOCAL REG. <b>12/30/60</b>	26. REGISTRAR'S SIGNATURE <i>[Signature]</i>	

(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  
or by \_\_\_\_\_, Student Embalmer No. \_\_\_\_\_  
working under my personal supervision.

Student \_\_\_\_\_  
Signature of Student Embalmer

Signed W<sup>m</sup> H. May

Licensed Embalmer No. 46

P. O. Address Advan

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