

RI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-60-048580

FILED VS. JAN. 6 1961 279

Primary Registration District No. 6287 Registrar's No. 5

STATE FILE NUMBER

1. PLACE OF DEATH a. COUNTY <u>WRIGHT</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MO.</u> b. COUNTY <u>WRIGHT</u>			
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWNSHIP <u>Pleasant Valley</u>		Length of stay in lb <u>Lifetime</u>		c. CITY OR TOWN <u>Seymour</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>Home</u>			Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <u>Rt 2</u>			Reside on Farm Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <u>MARY</u> Middle <u>R.</u> Last <u>Looper</u>				4. DATE OF DEATH Month <u>Dec.</u> Day <u>22</u> Year <u>1960</u>			
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</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>MAR. 16, 1885</u>	9. AGE (last birthday) <u>75</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>Housewife</u>			10b. KIND OF BUSINESS OR INDUSTRY <u> </u>		11. BIRTHPLACE (City and state, or country) <u>Wright Co., Mo.</u>		12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>
13a. FATHER'S NAME <u>Jerry B. Rush</u>			13b. MOTHER'S MAIDEN NAME <u>Theresa Sifert</u>		14. NAME OF HUSBAND OR WIFE <u>Charles H.</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>None</u>	17. INFORMANT <u>Charles H. Looper</u> Address <u>Seymour Mo</u>			RT 2
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>Cerebral Hemorrhage</u>							INTERVAL BETWEEN ONSET AND DEATH <u>4 days</u>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <u>Hypertension</u>							
DUE TO (c) <u>Arteriosclerosis</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 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 <u> </u> a.m. <u> </u> p.m. <u> </u> Month, Day, Year <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>Dec 19-60</u> to <u>Dec 22-60</u> and last saw her <u>alive</u> on <u>Dec 19-60</u> Death occurred at <u>7:50P</u> m on the date stated above, and to the best of my knowledge, from the causes stated.							
22a. SIGNATURE <u>DG Emme</u> (Degree or title) <u>DO</u>				22b. ADDRESS <u>Manfield Mo</u>		22c. DATE SIGNED <u>12/23/60</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE <u>12-24-60</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Seymour</u>		23d. LOCATION (City, town, or county) <u>Seymour</u> (State) <u>Mo.</u>		
24. FUNERAL DIRECTOR <u>Robert Bergman</u> ADDRESS <u>Bergman, Mo.</u>			25. DATE RECD. BY LOCAL REG. <u>12-26-60</u>		26. REGISTRAR'S SIGNATURE <u>[Signature]</u>		

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

1961 02 1961

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 Max J Miller

Licensed Embalmer No. 4720

P. O. Address Mansfield M

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.