

RI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-60-048600

FILED VS JAN 23 1961

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Primary Registration District No. 3010

Registrar's No. 31

STATE FILE NUMBER

DED

1. PLACE OF DEATH a. COUNTY <u>Cape Girardeau, Missouri</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Mississippi</u>											
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Cape Girardeau, Mo.</u>		Length of stay in lb		c. CITY OR TOWN <u>Wolf Island, Mo.</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>Cape Osteopathic Hosp.</u>			Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location) <u>Wolf Island, Mo.</u>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>								
3. NAME OF DECEASED (Type or print) First <u>Jerry</u> Middle <u>Lee</u> Last <u>Willis</u>				4. DATE OF DEATH Month <u>Dec.</u> Day <u>22</u> Year <u>1960</u>											
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. Married <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>		8. DATE OF BIRTH <u>12-22-60</u>		9. AGE (last birthday) <u>3 Hours</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)				10b. KIND OF BUSINESS OR INDUSTRY				11. BIRTHPLACE (City and state or country) <u>Cape Girardeau, Mo. USA</u>		12. CITIZEN OF WHAT COUNTRY <u>USA</u>					
13a. FATHER'S NAME <u>Unknown</u>				13b. MOTHER'S MAIDEN NAME <u>Sarah Willis</u>				14. NAME OF HUSBAND OR WIFE							
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.				17. INFORMANT <u>Sarah Willis, Wolf Island, Mo.</u>				Address			
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>Pulmonary hemorrhage</u> DUE TO (b) <u>Unknown</u> DUE TO (c) <u>Fetus delivered by Caesarian Section</u> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.										INTERVAL BETWEEN ONSET AND DEATH <u>1/2 hr</u>					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>Premature placental separation</u>										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.		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 <u>12/22/60</u> to <u>12/22/60</u> and last saw her/him alive on <u>12/22/60</u> Death occurred at <u>6:36 AM</u> m on the date stated above, and to the best of my knowledge, from the causes stated.															
22a. SIGNATURE <u>D. P. Foutner M.D.</u> (Degree or title)						22b. ADDRESS <u>Wyers, Mo.</u>						22c. DATE SIGNED <u>1-27-61</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>			23b. DATE <u>12-23-60</u>			23c. NAME OF CEMETERY OR CREMATORY <u>W.O.W Cemetery</u>			23d. LOCATION (City, town, or county) (State) <u>East Prairie, Missouri</u>						
24. FUNERAL DIRECTOR <u>Travis Shelby, East Prairie, Mo.</u>					ADDRESS		25. DATE RECD. BY LOCAL REG. <u>1-19-61</u>		26. REGISTRAR'S SIGNATURE <u>Jimmie Kasten</u>						

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

T. Davis Shelby Jr.

Licensed Embalmer No. 4940

P. O. Address

East Point

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.