

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

FILED VS JAN 10 1961

=61-000091

STATE FILE NUMBER

AMENDED

Registration District No. 10 Primary Registration District No. 5037 Registrar's No. 2

1. PLACE OF DEATH				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)			
a. COUNTY <u>Audrain</u>		b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Salt River Twp</u>		c. CITY OR TOWN <u>Mexico</u>		d. STREET ADDRESS (If outside, give location) <u>R. F. D. #2</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Salt River Twp</u>		Length of stay in 1b <u>6 yrs</u>		e. STATE <u>Missouri</u> b. COUNTY <u>Audrain</u>		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>Caldwell Nursing Home</u>				Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>		Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>Mary Belle (Mollie) Tease</u>				4. DATE OF DEATH Month Day Year <u>Jan. 4, 1961</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>		8. DATE OF BIRTH <u>12/29/82</u>	
9. AGE (last birthday) <u>78</u>		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) <u>Nursing home Patient</u>				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (City and state or country) <u>Callaway County, Mo. USA</u>	
12. CITIZEN OF WHAT COUNTRY							
13a. FATHER'S NAME <u>John W. Tate</u>				13b. MOTHER'S MAIDEN NAME <u>Hanna Ruth Boone</u>		14. NAME OF HUSBAND OR WIFE <u>S. D. Tease, Dec'd</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.		17. INFORMANT Address <u>Walter S. Palmer Mexico, 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>Carcinoma of the jaw that</u> <u>Smudged</u> DUE TO (b) DUE TO (c) <u>Smudged</u>				INTERVAL BETWEEN ONSET AND DEATH <u>3 1/2 yrs</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 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 <u>Sept 1960</u> to <u>Nov-60</u> and last saw her <u>alive on Dec 12-60</u>				Death occurred at _____ m on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE <u>D. O.</u> (Degree or title)				22b. ADDRESS <u>Mexico, Mo.</u>		22c. DATE SIGNED <u>1/5/61</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE <u>1/6/61</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Elmwood</u>		23d. LOCATION (City, town, or county) (State) <u>Mexico, Missouri</u>	
24. FUNERAL DIRECTOR <u>Arnold Funeral Home Mexico, Mo.</u> ADDRESS				25. DATE RECD. BY LOCAL REG. <u>Jan 5-1961</u>		26. REGISTRAR'S SIGNATURE <u>Blanche Neely</u>	

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

DATE AMENDED

INSTEAD OF

SHOULD READ

ITEM NO.

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 me,
or by _____, Student Embalmer No. _____
working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed Richard Y. M. Donald

Licensed Embalmer No. 4825

P. O. Address Mexico Mo

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.