

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-61-000590

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

STATE FILE NUMBER

Registration District No. 39 Primary Registration District No. _____ Registrar's No. 14

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS
 INSTEAD OF
 DATE AMENDED
 ITEM NO. SHOULD READ
 BY AFFIDAVIT OF

1. PLACE OF DEATH
 a. COUNTY CASS
 b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN STRASBURG Length of stay in 1b XX
 c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION XX Crossing Inside Limits Yes No

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
 a. STATE MISSOURI b. COUNTY JOHNSON
 c. CITY OR TOWN HOLDEN Inside Limits Yes No
 d. STREET ADDRESS (If outside, give location) XX Reside on Farm Yes No

3. NAME OF DECEASED (Type or print) First Middle Last
DONNA IRENE FERRIS
 4. DATE OF DEATH Month Day Year
January 9, 1961

5. SEX Female 6. COLOR OR RACE White 7. Married Never Married Widowed Divorced
 8. DATE OF BIRTH 4-4-157 9. AGE (last birthday) 3 years IF UNDER 1 YEAR Months 9 Days 3 IF UNDER 24 HR Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) child 10b. KIND OF BUSINESS OR INDUSTRY XX 11. BIRTHPLACE (City and state or country) Warrensburg, Mo. 12. CITIZEN OF WHAT COUNTRY U.S.A.

13a. FATHER'S NAME Albert Ferris 13b. MOTHER'S MAIDEN NAME Mildred Irene Riley 14. NAME OF HUSBAND OR WIFE XXXXXX

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) XX 16. SOCIAL SECURITY NO. none 17. INFORMANT Address Albert Ferris Holden, 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 Trauma INTERVAL BETWEEN ONSET AND DEATH Instant
 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) _____ 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.) Auto and Train Collision

20c. TIME OF INJURY Hour 1:15 Month, Day, Year 1-9-61 p.m. _____

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.) Railroad Crossing 20f. CITY, TOWN, OR LOCATION Strasburg COUNTY Cass STATE Mo

21. I attended the deceased from _____ to _____ and last saw her/him alive on _____
 Death occurred at 1-9-61 1:15 p.m. on the date stated above, and to the best of my knowledge, from the causes stated.

22. SIGNATURE (Degree or title) Blenn Cummins Crowners Co 22b. ADDRESS Warrensburg Mo 22c. DATE SIGNED 1-9-61

23a. BURIAL, CREMATION, REBURY (Specify) Burial 23b. DATE 1-12-61 23c. NAME OF CEMETERY OR CREMATORY Kingsville Cemetery 23d. LOCATION (City, town, or county) (State) Kingsville, Missouri

24. FUNERAL DIRECTOR Canaday & Ropp ADDRESS Holden, Missouri 25. DATE RECD. BY LOCAL REG. Jan-11-1961 26. REGISTRAR'S SIGNATURE Mrs Ray Sebee

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 M. K. Casaday

Licensed Embalmer No. 3434

P. O. Address Holden 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.