

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-61-008074  
STATE FILE NUMBER

Registration District No. 75 Primary Registration District No. 3015 Registrar's No. 24

AMENDED

FILED MAR 20 1961

1. PLACE OF DEATH a. COUNTY <b>Clinton</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Mo.</b> b. COUNTY <b>Clinton</b>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>Cameron</b>		Length of stay in lb <b>2 days</b>	c. CITY OR TOWN <b>Osborn</b> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>Cameron Comm.Hosp.</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <b>General Delivery</b> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print) First <b>FLORENCE</b> Middle <b>ADA</b> Last <b>MORELAND</b>			4. DATE OF DEATH Month <b>Mar.</b> Day <b>8,</b> Year <b>1961</b>			
5. SEX <b>Female</b>	6. COLOR OR RACE <b>Cauc.</b>	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <b>4-25-1896</b>	9. AGE (last birthday) <b>64</b>	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HR Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Home</b>		11. BIRTHPLACE (City and state or country) <b>MT.Pleasant, Iowa</b>		12. CITIZEN OF WHAT COUNTRY <b>U.S.A.</b>
13a. FATHER'S NAME <b>Otto Shultz</b>		13b. MOTHER'S MAIDEN NAME <b>Ada A.Ridhards</b>		14. NAME OF HUSBAND OR WIFE <b>Deceased</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>no</b>		17. INFORMANT Address <b>Robert Moreland, Kansas City, Mo.</b>		

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral Hemorrhage</b>		INTERVAL BETWEEN ONSET AND DEATH <b>3 min</b>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) <b>Arteriosclerotic Heart Disease</b>	<b>10 yrs</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 checked="" 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.) <b>-</b>	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m.		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 3-10-61 to 3-7-61 and last saw her alive on 3-7-61  
Death occurred at 1:30 AM on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) <b>J. Hetherington</b>		22b. ADDRESS <b>M.D. Cameron, Mo.</b>		22c. DATE SIGNED <b>3-10-61</b>
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE <b>3-10-1961</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Evergreen</b>	23d. LOCATION (City, town, or county) (State) <b>Osborn, Mo.</b>	

24. FUNERAL DIRECTOR ADDRESS <b>Poland Funeral Home, Cameron, Mo.</b>		25. DATE RECD. BY LOCAL REG. <b>March 10</b>	26. REGISTRAR'S SIGNATURE <b>Francis D Crawford</b>
--	--	---	--

DATE AMENDED

INSTEAD OF

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

ITEM NO. SHOULD READ

**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 Robert F. Poloud

Licensed Embalmer No. 4777  
222 West 3  
P. O. Address Cameron, N.C.

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.