

AMENDED

Registration District No. 141 Primary Registration District No. 3025 Registrar's No. 36

FILED VS MAR 13 1961

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| 1. PLACE OF DEATH a. COUNTY <u>Waverly</u> | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Mo</u> b. COUNTY <u>Waverly</u> | |
| b. CITY (if outside corporate limits, give TOWNSHIP only) OR TOWN <u>West Plains</u> Length of stay in lb <u>2 wks</u> | | c. CITY OR TOWN <u>West Plains</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> | |
| c. FULL NAME OF (if NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>Memorial Hosp.</u> Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/> | | d. STREET ADDRESS (If outside, give location) <u>401 W. Cleveland</u> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) First <u>Jim J. Fay</u> Middle <u></u> Last <u></u> | | | 4. DATE OF DEATH Month <u>2</u> Day <u>27</u> Year <u>61</u> |
| 5. SEX <u>M</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>3-2-84</u> 9. AGE (last birthday) <u>76</u> |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired Farmer</u> | | 10b. KIND OF BUSINESS OR INDUSTRY <u></u> | 11. BIRTHPLACE (City and state or country) <u>Waverly Co. Mo</u> 12. CITIZEN OF WHAT COUNTRY <u>USA</u> |
| 13. FATHER'S NAME <u>Jeff Fay</u> | | 13b. MOTHER'S MAIDEN NAME <u>Mary Stewart</u> | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) <u></u> | | 16. SOCIAL SECURITY NO. <u>yes</u> 17. INFORMANT <u>Mrs. S. J. Fay, West Plains Mo</u> Address <u></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>Cardiac Insufficiency</u> INTERVAL BETWEEN ONSET AND DEATH <u>24 hrs</u> DUE TO (b) <u>Cerebral Vascular Thrombosis</u> <u>4 days</u> DUE TO (c) <u>Arteriosclerotic Heart Disease</u> <u>5 yrs</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>Left Ventricular Hypertrophy</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"/> | |
| 20c. TIME OF INJURY Hour <u></u> Month, Day, Year <u></u> | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.) <u></u> | |
| 20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/> | | 20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <u></u> | |
| | | 20f. CITY, TOWN, OR LOCATION <u></u> COUNTY <u></u> STATE <u></u> | |
| 21. I attended the deceased from <u>1-25-1961</u> to <u>2-26-61</u> and last saw her <u>live</u> on <u>2-26-61</u> at <u>12:10 a.</u> Death occurred at <u></u> on the date stated above, and to the best of my knowledge, from the causes stated. | | | |
| 22a. SIGNATURE (Degree or title) <u>Murray B. Pritchard, D.O.</u> | | 22b. ADDRESS <u>913 W. Main West Plains, Mo.</u> | |
| 22c. DATE SIGNED <u>3-7-61</u> | | | |
| 23a. FUNERAL CREMATION REMOVAL (Specify) <u></u> | | 23b. DATE <u>3-1-61</u> | |
| 23c. NAME OF CEMETERY OR CREMATORY <u>Union Groves</u> | | 23d. LOCATION (City, town, or county) <u>West Plains Mo</u> | |
| 24. FUNERAL DIRECTOR <u>Robertson West Plains Mo</u> ADDRESS <u></u> | | 25. DATE RECD. BY LOCAL REG. <u>3-8-61</u> | |
| | | 26. REGISTRAR'S SIGNATURE <u>Beatrice Cook</u> | |

DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

ITEM NO. SHOULD READ

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 *A. S. Roberts*

Licensed Embalmer No. 3437

P.O. Address West Va

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.