

SOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

=61-009881

FILED VS MAR 13 1961

STATE FILE NUMBER

AMENDED

Registration District No. 226 Primary Registration District No. 4252 Registrar's No. 15

1. PLACE OF DEATH a. COUNTY <u>Morgan</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Mo.</u> b. COUNTY <u>Morgan</u>									
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Versailles</u>		Length of stay in 1b <u>20 years</u>		c. CITY OR TOWN <u>Versailles</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>W. Jasper St.</u>			Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location) <u>W. Jasper St.</u>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>						
3. NAME OF DECEASED (Type or print) First <u>Wesley</u> Middle <u>Clark</u> Last <u>Howland</u>				4. DATE OF DEATH Month <u>March</u> Day <u>3</u> Year <u>1961</u>									
5. SEX <u>Male</u>		6. COLOR OR RACE <u>Cos.</u>		7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input checked="" type="checkbox"/>		8. DATE OF BIRTH <u>4-23-1877</u>		9. AGE (last birthday) <u>89</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>Cabinet Maker</u>				10b. KIND OF BUSINESS OR INDUSTRY				11. BIRTHPLACE (City and state or country) <u>Bolckow, Mo.</u>		12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>			
13a. FATHER'S NAME <u>Wm H. Howland</u>				13b. MOTHER'S MAIDEN NAME <u>Elizabeth Clark</u>				14. NAME OF HUSBAND OR WIFE <u>Unknown</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>Miss May Howland St. Joseph, 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>Cerebral Hemorrhage</u>										INTERVAL BETWEEN ONSET AND DEATH <u>12 hours</u>			
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) <u>Pneumonia</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 _____ s.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>1954</u> to <u>present</u> and last saw him alive on <u>March 3, 1961</u> Death occurred at <u>6:30 P.M.</u> on the date stated above, and to the best of my knowledge, from the causes stated.													
22a. SIGNATURE (Degree or title) <u>Ruth Kauffman, M.D.</u>						22b. ADDRESS <u>Versailles, Mo</u>				22c. DATE SIGNED <u>3-7-61</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE <u>7 March 61</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Versailles</u>		23d. LOCATION (City, town, or county) (State) <u>Versailles, Mo.</u>							
24. FUNERAL DIRECTOR ADDRESS <u>Kidwell Funeral Home Versailles, Mo.</u>				25. DATE RECD. BY LOCAL REG. <u>3-7-61</u>		26. REGISTRAR'S SIGNATURE <u>J. L. Wash</u>							

DATE AMENDED

INSTEAD OF

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

ITEM NO. SHOULD READ

MAR 14 1961

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 Raymond L. Fisher

Licensed Embalmer No. 4626

P. O. Address New Orleans, La.

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.