

MOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-61-018659

STATE FILE NUMBER

Registration District No. 301 Primary Registration District No. _____ Registrar's No. 31

AMENDED

FILED MAY 24 1961

1. PLACE OF DEATH a. COUNTY <u>Ripley</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Ripley</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) <u>Doniphan</u>		c. CITY OR TOWN <u>Doniphan</u>	
Length of stay in 1b <u>12 days</u>		Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) <u>Ripley Co. Memorial Hosp</u>		d. STREET ADDRESS (If outside, give location) <u>R#1</u>	
Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		Reside on Farm Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	

3. NAME OF DECEASED (Type or print) First <u>Sue</u> Middle <u>M.</u> Last <u>DALTON</u>			4. DATE OF DEATH Month <u>April</u> Day <u>29</u> Year <u>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>5-4-1869</u>	9. AGE (last birthday) <u>91</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>Housewife</u>	10b. KIND OF BUSINESS OR INDUSTRY <u>Home</u>	11. BIRTHPLACE (City and state or country) <u>Marion, Va</u>	12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>
---	--	---	--

13a. FATHER'S NAME <u>George Thomas</u>	13b. MOTHER'S MAIDEN NAME <u>MARY ANN HAMMONDS</u>	14. NAME OF HUSBAND OR WIFE <u>MARY PHILLIPS</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. <u>None</u>	17. INFORMANT <u>MARY PHILLIPS</u>	Address <u>DONIPHAN, Mo.</u>
---	--	---------------------------------------	---------------------------------

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY:		INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a)	<u>Cerebral Hemorrhage</u>	<u>18 hours</u>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) <u>generalized arteriosclerosis</u>	<u>15 years</u>
	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 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 checked="" 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 June 1956 to April 29, 1961 and last saw her/him alive on April 29, 1961
Death occurred at 10:00 A m on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) <u>Frank Johnson MD</u>	22b. ADDRESS <u>Doniphan Mo</u>	22c. DATE SIGNED <u>5/1/61</u>
---	------------------------------------	-----------------------------------

23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	23b. DATE <u>May 1, 1961</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Doniphan Cemetery</u>	23d. LOCATION (City, town, or county) (State) <u>Doniphan Missouri</u>
--	---------------------------------	--	---

24. FUNERAL DIRECTOR <u>Edwards Funeral Home</u>	ADDRESS <u>Doniphan, Mo.</u>	25. DATE RECD. BY LOCAL REG. <u>5-11-61</u>	26. REGISTRAR'S SIGNATURE <u>Flora Broz</u>
---	---------------------------------	--	--

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 Gene Harrent

Licensed Embalmer No. 4809

P. O. Address Taylor, 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.