SSOURI DIVISION OF HEALTH – STANDARD CERTIFICATE OF DEATH

-61-020177
STATE FILE NUMBER

AMENDED

Registration District No. 360 Primary Registration District No. 6225 Registrar's No. 82

FILED JUN 13 1961

1. PLACE OF DEATH
a. COUNTY Vernon
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Washington Township — Length of stay in 1b: 1 Year 4 months
c. FULL NAME OF HOSPITAL OR INSTITUTION State Hosp. # 3 — Inside Limits Yes ☐ No ☒

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Mo. b. COUNTY Newton
c. CITY OR TOWN Neosho — Inside Limits Yes ☒ No ☐
d. STREET ADDRESS (If outside, give location) 345 S. Wood Street — Reside on Farm Yes ☐ No ☒

3. NAME OF DECEASED (Type or print): First Erie Middle Hortense Last Loehr
4. DATE OF DEATH Month Day Year: 6-5-61
5. SEX: Female
6. COLOR OR RACE: White
7. Married ☐ Never Married ☐ Widowed ☒ Divorced ☐
8. DATE OF BIRTH: 4-19-80
9. AGE (last birthday): 80 — 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): Retired Seamstress
10b. KIND OF BUSINESS OR INDUSTRY: Dressmaking
11. BIRTHPLACE (City and state or country): Indiana
12. CITIZEN OF WHAT COUNTRY: U.S.A.
13a. FATHER'S NAME: George Moore
13b. MOTHER'S MAIDEN NAME: Martha Foster
14. NAME OF HUSBAND OR WIFE: Deceased (Unknown)
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): no — (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.: None
17. INFORMANT: Records — Address: State Hospital # 3, Nevada, Mo.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Pulmonary Tuberculosis — INTERVAL BETWEEN ONSET AND DEATH: Years
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.
DUE TO (b) Coronary Vessel Disease — Years
DUE TO (c)
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) Chronic Brain Syndrome Assoc. with Circ. Dist. with Cerebral Arteriosclerosis, with Psychosis.
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.)
20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year
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.)
20f. CITY, TOWN, OR LOCATION COUNTY STATE

21. I attended the deceased from 1-26-60, to 6-5-61 and last saw her alive on 6-5-61
Death occurred at 12:45 p.m. on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) E. Allen Pickens, M.D.
22b. ADDRESS State Hosp. # 3, Nevada, Mo.
22c. DATE SIGNED 6-5-61

23a. BURIAL, CREMATION, REMOVAL (Specify): burial
23b. DATE: 6-5-1961
23c. NAME OF CEMETERY OR CREMATORY: I. O. O. F. Cemetery
23d. LOCATION (City, town, or county) (State): Neosho, Missouri

24. FUNERAL DIRECTOR: Thompson Funeral Home — ADDRESS: Neosho, Missouri
25. DATE REC'D BY LOCAL REG.: June 7-1961
26. REGISTRAR'S SIGNATURE: Anna E. Ferry

(Licensed Embalmer's Statement on Reverse Side)

DATE AMENDED | INSTEAD OF | DOCUMENT | SHOULD READ | BY AFFIDAVIT OF | ITEM NO.

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 L. Hugler Ferry

Licensed Embalmer No. 4960

P. O. Address Nevada,

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.