

MOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-61-021837
STATE FILE NUMBER

Registration District No. 385 Primary Registration District No. 2039 Registrar's No. 16

AMENDED

FILED JUN 16 1961

| | | | |
|--|--|---|---|
| 1. PLACE OF DEATH a. COUNTY <u>Linn</u> | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MO</u> b. COUNTY <u>Linn</u> | |
| b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Marceline</u> | | Length of stay in 1b <u>24 hrs</u> | c. CITY OR TOWN <u>Marceline</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>St Francis Hosp</u> | | Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> | d. STREET ADDRESS (If outside, give location) <u>E. Booker</u> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> |

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|--|---------------------------|--|---|--|---|--|
| 3. NAME OF DECEASED (Type or print) First <u>Sarah</u> Middle <u>J.</u> Last <u>DeJ</u> | | | 4. DATE OF DEATH Month <u>5</u> - Day <u>30</u> - Year <u>61</u> | | | |
| 5. SEX <u>F</u> | 6. COLOR OR RACE <u>W</u> | 7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/> | 8. DATE OF BIRTH <u>3-7-1888</u> | 9. AGE (last birthday) <u>78</u> | IF UNDER 1 YEAR Months <u>9</u> Days <u>23</u> | IF UNDER 24 HR Hours <u></u> Min. <u></u> |
| 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>same</u> | | 11. BIRTHPLACE (City and state or country) <u>Browning, MO</u> | | 12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u> |
| 13a. FATHER'S NAME <u>Henry McKays</u> | | 13b. MOTHER'S MAIDEN NAME <u>Margaret Hines</u> | | 14. NAME OF HUSBAND OR WIFE <u>Samuel (dec)</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>Richard DeJ</u> Address <u>Marceline, MO</u> | | |

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| 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>36 hrs</u> <u>4 years</u> |
| DUE TO (b) <u>hypertensive Cardiovascular disease</u> | | |
| DUE TO (c) <u></u> | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>Previous CVA - Cardiac decompensation</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 |

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|---|---|--|
| 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 <u></u> Month, Day, Year <u></u> a.m. <u></u> p.m. <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.) | 20f. CITY, TOWN, OR LOCATION COUNTY STATE |

21. I attended the deceased from 1958 to May 30, 1961 and last saw her alive on May 30 1961
Death occurred at 11 P m on the date stated above, and to the best of my knowledge, from the causes stated.

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|--|-------------------------|--|--|---------------------------------|
| 22a. SIGNATURE (Degree or title) <u>George Gaymy</u> | | 22b. ADDRESS <u>Marceline Missouri</u> | | 22c. DATE SIGNED <u>5-31-61</u> |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <u>B</u> | 23b. DATE <u>6-1-61</u> | 23c. NAME OF CEMETERY OR CREMATORY <u>MT Olive</u> | 23d. LOCATION (City, town, or county) (State) <u>Marceline, MO</u> | |
| 24. FUNERAL DIRECTOR <u>James M. Laughlin</u> ADDRESS <u>Marceline, MO</u> | | 25. DATE RECD. BY LOCAL REG. <u>May 31-61</u> | 26. REGISTRAR'S SIGNATURE <u>Anna Watson</u> | |

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 *Herold J. Wade*

Licensed Embalmer No. 4172

P. O. Address *Brown*

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.