

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-61-024606

STATE FILE NUMBER

Registration District No. 096 Primary Registration District No. _____ Registrar's No. 40

AMENDED

FILED AUG 10 1961

1. PLACE OF DEATH a. COUNTY Dallas		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY Dallas	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN 9 Yrs.		c. CITY OR TOWN 7 Mi. N. of Buffalo	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION 7 Mi. N. of Buffalo		d. STREET ADDRESS (If outside, give location) 7 Mi. N. of Buffalo	
3. NAME OF DECEASED (Type or print) First RUTH Middle E. Last SHOWALTER		4. DATE OF DEATH Month July Day 25 Year 1961	
5. SEX female	6. COLOR OR RACE white	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH Feb. 16, 1885
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife		10b. KIND OF BUSINESS OR INDUSTRY housework	11. BIRTHPLACE (City and state or country) Kansas
13a. FATHER'S NAME John Potter		13b. MOTHER'S MAIDEN NAME Gertrude Dewey	14. NAME OF HUSBAND OR WIFE Philip Showalter
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO.	17. INFORMANT Address Philip Showalter Buffalo, Mo.
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Hemorrhage Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. } DUE TO (b) Hypertension DUE TO (c) Arteriosclerosis			INTERVAL BETWEEN ONSET AND DEATH 10-12 yrs 12 yrs
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 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 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 1955 to 7-25-61 and last saw her ^{her} _{him} alive on 7-9-61 Death occurred at 11:00 a.m. on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree or title) O. Bruffen md		22b. ADDRESS Buffalo mo	22c. DATE SIGNED 28 July 61
23a. BURIAL, CREMATION, REMOVAL (Specify) burial	23b. DATE July 28, 1961	23c. NAME OF CEMETERY OR CREMATORY - New Hope	23d. LOCATION (City, town, or county) (State) Dallas Co. Mo.
24. FUNERAL DIRECTOR ADDRESS L. B. Jones Buffalo, Mo.		25. DATE RECD. BY LOCAL REG. 8/7/1961	26. REGISTRAR'S SIGNATURE <i>[Signature]</i>

DATE AMENDED

INSTEAD OF

DOCUMENT

MEDICAL CERTIFICATION

SHOULD READ

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 me, Student Embalmer No. ✓

working under my personal supervision.

Student ✓
Signature of Student Embalmer

Signed R.E. Cheatham

Licensed Embalmer No. 3813

P. O. Address Buffalo, N.Y.

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.