

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-61-026446

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

STATE FILE NUMBER

AMENDED

Registration District No. 316

Primary Registration District No. —

Registrar's No. 231

FILED JUN 21 1961

1. PLACE OF DEATH a. COUNTY <u>St. Francois</u>			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Mo.</u> b. COUNTY <u>CARTER</u>		
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Rural St. Francois Farmington Twp.</u>		Length of stay in 1b <u>1Yr.; 1M; 25 days</u>		c. CITY OR TOWN <u>ELLSINORE</u>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>State Hospital # 4</u>		Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>		d. STREET ADDRESS (If outside, give location) <u>Rt 1</u>	
3. NAME OF DECEASED (Type or print) First <u>William</u> Middle <u>Cody</u> Last <u>Andrews</u>			4. DATE OF DEATH Month <u>JUNE</u> Day <u>6</u> Year <u>1961</u>		
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <u>4-4-1898</u>	9. AGE (last birthday) <u>63</u> Months <u>2</u> Days <u>2</u>	IF UNDER 1 YEAR IF UNDER 24 HR Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farming</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Farming</u>		11. BIRTHPLACE (City and state or country) <u>LAWSON MO</u>	
13a. FATHER'S NAME <u>JAMES Andrews</u>		13b. MOTHER'S MAIDEN NAME <u>Lucy Kenman</u>		14. NAME OF HUSBAND OR WIFE <u>Genevieve Andrews</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. ADDRESS <u>State Hospital No. 4, Rt 1, ELLSINORE 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>Coronary Occlusion - - - - - Instantaneous.</u> DUE TO (b) <u>Coronary Sclerosis - - - - - Unknown.</u> DUE TO (c) _____ Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>Chronic brain syndrome with cerebral arteriosclerosis with psychotic reaction.</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 _____ Month, Day, Year _____ a.m. _____ p.m. _____					
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>April 11, 1960</u> to <u>June 6, 1961</u> and last saw him alive on <u>June 6, 1961</u> Death occurred at <u>1:25 P</u> on the date stated above, and to the best of my knowledge, from the causes stated.					
22a. SIGNATURE (Degree or title) <u>J. P. Brennan, M.D.</u>			22b. ADDRESS <u>State Hospital No. 4 Farmington, Missouri</u>		22c. DATE SIGNED <u>6-6-61</u>
23. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>	23b. DATE <u>June 6, 1961</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Whites Mill</u>		23d. LOCATION (City, town, or county) (State) <u>Carter Co MO</u>	
24. FUNERAL DIRECTOR <u>McSpadden</u>		ADDRESS <u>Funeral Home Van Buren</u>		25. DATE RECD. BY LOCAL REG. <u>June 6, 1961</u>	26. REGISTRAR'S SIGNATURE <u>Ether Ruddy</u>

DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

INSTEAD OF

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

SHOULD READ

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 Donald Sloan

Licensed Embalmer No. 5127

P. O. Address VAN BUREN, M

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.